

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #9 Film #G3884/25/67 pc

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05272

05270

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRINGS</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>STANLEY</b>		First <b>RAYMOND</b>	Middle <b>ACKERMAN</b>
4. DATE OF DEATH <b>APRIL 15 1967</b>		Month <b>APRIL</b>	Doy Year <b>15 67</b>
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUC</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US NAVY</b>		9. DATE OF BIRTH <b>JAN. 27, 1934</b>	
10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>COZAD, NEBR.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN R. ACKERMAN</b>	
14. MOTHER'S MAIDEN NAME <b>LELIA HALVERSTADT</b>		15. SOCIAL SECURITY NO. <b>507 36 0383</b>	
16. INFORMANT <b>MARIANNE T. ACKERMAN</b>		17. ADDRESS <b>4704 ASPEN HILL ROAD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b> (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20b. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JOHN G. BALL MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/17/1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>UNKNOWN</b>		23d. LOCATION (City or Town) (County) (State) <b>COZAD, NEBR.</b>	
24. FUNERAL DIRECTOR <b>T.S.C. CHAMBERS CO - WASHINGTON, D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 20 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

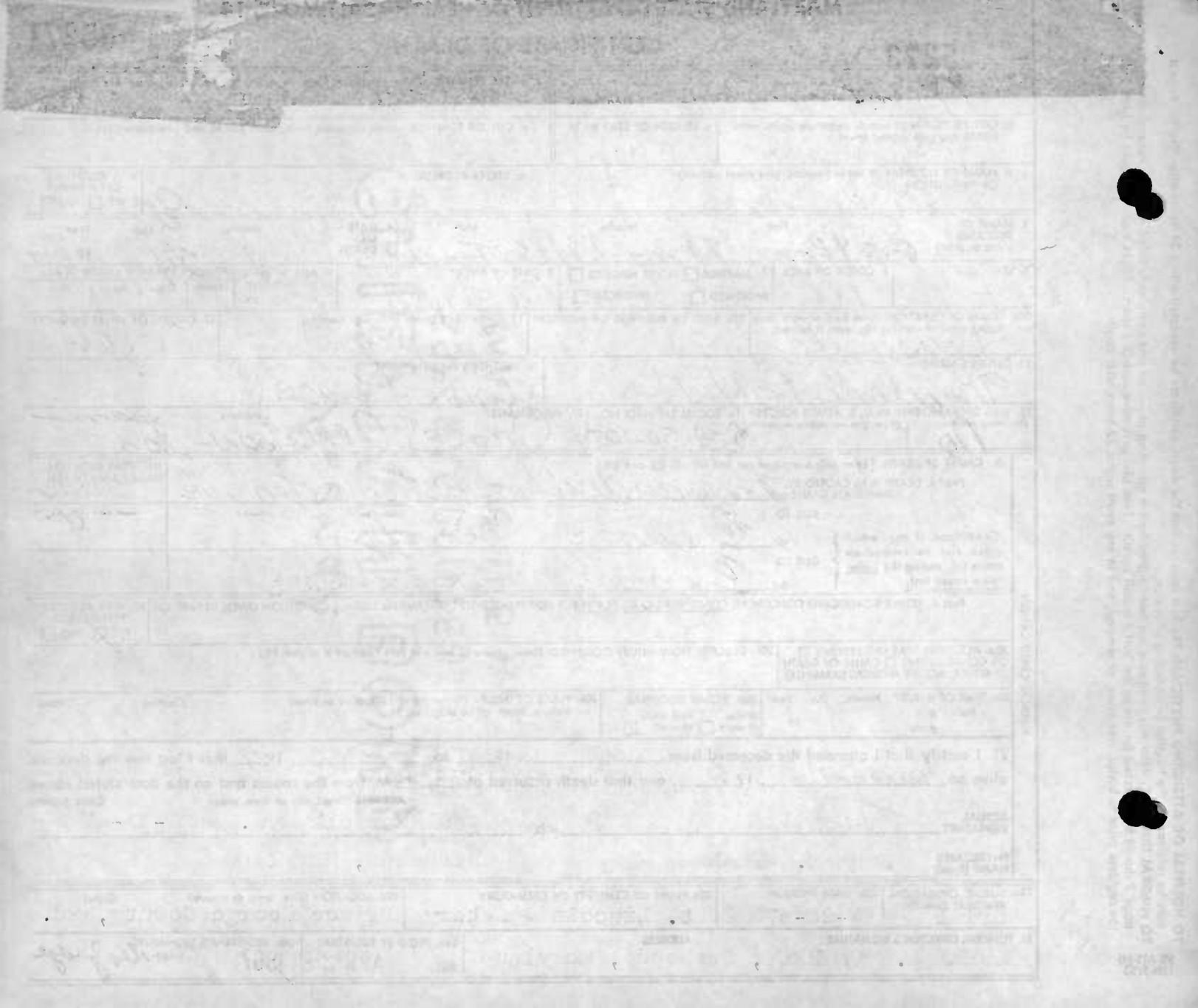
05271

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Montgomery Maryland		a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Bethesda		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47.3	
3. NAME OF DECEASED (Type or print) Esther May Albertson		d. STREET ADDRESS 5133 Broad Branch Rd	
First Middle Last		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F W		4. DATE OF DEATH Month 4 Day 24 Year 1967	
6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 2, 1901		9. AGE (in years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY New York	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Meadore Pollak		14. MOTHER'S MAIDEN NAME Annie Work	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 230-50-1254 17. INFORMANT James Albertson - Son Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Myocardial infarction, extensive	
(b) DUE TO Coronary thrombosis			
(c) DUE TO Coronary arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1967, to April 24, 1967, that I last saw the deceased alive on July 1, 1967, and that death occurred at 7:03 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John M. Wyman		ADDRESS (Street, city or town, state) 7801 Norfolk Ave. Bethesda, Maryland DATE SIGNED 4-25-67	
PHYSICIAN'S NAME (Type) JOHN M. WYMAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-28-67	
22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) Prince George County, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE APR 28 1967	
		24b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

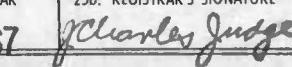
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## CERTIFICATE OF DEATH

05272

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>California</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. STREET ADDRESS <b>5256 Willow Wood</b>		f. DATE OF DEATH <b>April 3 1967</b>	
3. NAME OF DECEASED (Type or print) <b>Alton S. ALLBRITTON</b>		First <b>A</b>	Middle <b>S.</b>
4. LAST <b>ALLBRITTON</b>	Last <b>A</b>	Month <b>April</b>	Day <b>3</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 5, 1914</b>
8. 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy (Ret'd)</b>		9. AGE (In years last birthday) <b>52 yrs.</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Arcadia, Florida</b>	
13. FATHER'S NAME <b>William C. Allbritton</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>Yes WW II Korea -1958</b>		16. SOCIAL SECURITY NO. <b>44-1444-4444</b>	
17. INFORMANT <b>Rolling Hills Estates, Calif.</b>		Mrs. Tolona Allbritton, 5256 Willow Wood	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH 193X DUE TO _____ Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Naval Hospital, Bethesda, Maryland</b>
20f. (City or town) <b>Naval Hospital</b> (County) <b>Bethesda</b> (State) <b>Maryland</b>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 30, 1967</b> , to <b>April 3, 1967</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 3, 1967</b> , and that death occurred at <b>1250 PM</b> from causes and on the date stated above.			
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>April 4, 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 5-1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>
23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>		23e. ADDRESS <b>Simmons Brothers Funeral Home</b>	
23f. FUNERAL DIRECTOR <b>1661 Good Hope Road, S. E., Washington, D.C.</b>		23g. REC'D BY REGISTRAR <b>APR 6 1967</b>	23h. REGISTRAR'S SIGNATURE 

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05275

## CERTIFICATE OF DEATH

05273

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb <b>19 days.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hosp. of Silver Spring</b>		e. STREET ADDRESS <b>Apt 105 - 2100 Connecticut Ave</b>	
f. FIRST MIDDLE LAST <b>Samuel R. Amato</b>		4. DATE OF DEATH Month Day Year <b>APRIL 24 1967</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>3/4/00</b>		9. AGE (In years lost birthday) yrs. <b>67 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner BUSINESS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PARKING LOT</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>IGNATIUS AMATO</b>		14. MOTHER'S MAIDEN NAME <b>ROSA DECRISTINA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-05-7747</b>	
17. INFORMANT <b>GRACE B. AMATO - SEE ITEM #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Colon</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1966</b> , to <b>4/24 1967</b> , that (I) (we) last saw the deceased alive on <b>4/23 1967</b> , and that death occurred at <b>3:00 A.M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>4/24/67</b>	
22a. SIGNATURE <b>G. Lennard Gold</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>G. Lennard Gold, M.D.</b>		22d. ADDRESS <b>8641 Colesville Rd., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>4-29-1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Fairview Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bethel, Vermont</b>	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR DATE <b>APR 26 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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STUDENTS

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the building of a new library

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05276		CERTIFICATE OF DEATH						05274		
1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Virginia</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda(rural)</b>		c. LENGTH OF STAY IN lb <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norfolk</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>9632 Atlans Street</b>						
3. NAME OF DECEASED (Type or print) <b>Kenneth McArthur</b>		First <b>Kenneth</b>	Middle <b>McArthur</b>	Last <b>Andrews Jr.</b>	4. DATE OF DEATH <b>April 29 1967</b>	Month <b>April</b>	Doy <b>29</b>	Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11, 1967</b>	9. AGE (In years lost birthday) yrs. <b>18</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kenneth McArthur Andrews</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Portsmouth, Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Sandra Leigh Brown</b>				14. MOTHER'S MAIDEN NAME <b>9632 Atlans Street</b> <b>Kenneth M. Andrews Norfolk, Va.</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> Address (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.				17. INFORMANT <b>75-45</b>				18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>CONGENITAL HEART DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (o). stating the underlying cause (b) _____ lost. (c) _____		
19. MEDICAL CERTIFICATION				20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> 20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) p.m.		
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Apr. 29</b> , 19 <b>67</b> , to <b>Apr. 29</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>Apr. 29</b> , 19 <b>67</b> , and that death occurred at <b>840P</b> M, from causes and on the date stated above.				22. SIGNATURE <b>T.E. Kelly</b>				22b. DATE SIGNED <b>30 APRIL 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>T.E. KELLY MD</b>				22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>				23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 5-1-67</b>		
23b. DATE THEREOF <b>Indian Branch Cem.</b>				23c. NAME OF CEMETERY OR CREMATORIAL <b>DARLINGTON</b>				23d. LOCATION (City or Town) (County) (State) <b>S.C.</b>		
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b> ADDRESS <b>BETHESDA, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>MAY 3 1967</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
BELK-KING FUNERAL HOME, DARLINGTON, S.C.										

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FOR STATE  
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												05275							
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>				c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				d. STREET ADDRESS c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring Forest Glen Rd 2003 Lansdowne Way</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Walter J. Andrews</i>				First		Middle		Lost		4. DATE OF DEATH Month <i>April</i> Day <i>22</i> Year <i>1967</i>									
5. SEX <i>m</i>		6. COLOR OR RACE <i>w</i>		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <i>2-18-08</i>		9. AGE (In years last birthday) <i>61 yrs.</i>		IF UNDER 1 YEAR Months <i>0</i> Dots <i>0</i> Hours <i>0</i> Min. <i>0</i>		IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Prestige</i> .				10b. KIND OF BUSINESS OR INDUSTRY <i>Office Supply Equipment Wash DC</i>				11. BIRTHPLACE (State or foreign country) <i>Wash DC</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>							
13. FATHER'S NAME <i>Harry R. Andrews</i>				14. MOTHER'S MAIDEN NAME <i>MARY Finch</i>				15. INFORMANT <i>Ruth Andrews-WIFE Silver Spring, Md</i>				200 Address <i>Lansdowne Way</i>							
16. SOCIAL SECURITY NO. <i>577-09-5471</i>												17. INTERVAL BETWEEN ONSET AND DEATH <i>15-20 min</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial &amp; congestive ht. failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>420.1</i> (b) <i>Acute myocardial occlusion</i> DUE TO (c) <i>Coronary sclerosis, severe</i>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>None</i>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)															
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>p.m.</i> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Princetown</i> (County) <i>Prince Georges Co.</i> (State) <i>Md.</i>											
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>John S. Rogers Jr.</i> M.D. EXAMINER'S NAME (Type) <i>John S. Rogers Jr.</i> M.D. 1819 Seminole Avy Rd, Silver Spring, Md												22. DATE SIGNED <i>4-22-67</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr 25, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>				23d. LOCATION (City or Town) <i>Princetown</i> (County) <i>Prince Georges Co.</i> (State) <i>Md.</i>											
24. FUNERAL DIRECTOR <i>John B. Thomas Warner &amp; Son Inc.</i>		ADDRESS <i>8434 Georgia Avenue</i>		25a. REC'D BY REGISTRAR <i>APR 27 1967</i>				25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>											
VR A15ME (5) 6M 1/66																			

27520

1980-10-10 10:00:00 CRIMINAL DOCK

27520

VAC 100

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G387 4/11/67 po

## CERTIFICATE OF DEATH

05276

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WASH. D.C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kensington Gardens SANITARIUM</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George M. Anderson</b>		4. DATE OF DEATH Month <b>4</b>	Day <b>3</b> Year <b>1967</b>
S. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/27/1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PATENT ATTORNEY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LAW</b>	9. AGE (In years last birthday) <b>93 44 yrs.</b>
13. FATHER'S NAME <b>Edward W. Anderson</b>		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, not known) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>579-52-9524</b>	17. INFORMANT <b>4000 MASS AVE N.W. WASH DC.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIO-SCLEROTIC HEART DISEASE</b> <b>4200</b> DUE TO <b>WITH HEART FAILURE</b>		<b>3 MONTHS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>GERIALIZED ARTERIOSCLEROSIS (TERMINAL)</b> DUE TO <b>SENIORITY</b>		<b>20 YRS</b>	
(c) <b>PROSTATIC HYPERTROPHY</b>		<b>2 YRS f</b>	
		<b>10 YRS f</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Bladensburg</b>		(County) <b>MD</b>	
		(State) <b>MD</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 6, 1963</b> , to <b>3/22, 1967</b> , that (I) (we) last saw the deceased alive on <b>3/22, 1967</b> , and that death occurred at <b>5A. M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>4/3/67</b>	
22o. SIGNATURE <b>Rearmure S Donnelly</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>1827 23rd St. NW WASH DC 20008</b>
22c. PHYSICIAN'S NAME (Type) <b>Rearmure S Donnelly MD</b>		23d. LOCATION (City or Town) <b>Bladensburg</b> (County) <b>MD</b> (State) <b>MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-3-1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>MT OLIVET CEM</b>
24. FUNERAL DIRECTOR <b>W.W. Chambers Co</b>		ADDRESS <b>1400 Chapin St. N.W.</b>	25a. REC'D BY REGISTRAR <b>APR 4 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>

02526

02526

02526

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05279

## CERTIFICATE OF DEATH

05277

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Closed by Medical Examiner J. R. Coleman, M.D.*

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>7 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. STREET ADDRESS <u>735 Sligo Avenue</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>735 Sligo Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Josephine Klein</u>		First <u>J</u>	Middle <u>O</u>	Lost <u>A</u>	4. DATE OF DEATH <u>April 10 1967</u>	Month <u>April</u>	Doy <u>10</u>	Year <u>1967</u>
S. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 2, 1893</u>	9. AGE (In years last birthday) <u>74 yrs.</u>	IF UNDER 1 YEAR Months <u>0</u> Doy <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Michael Klein</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Tietjen</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>			16. SOCIAL SECURITY NO. <u>Yes</u>	17. INFORMANT <u>Grover E. Asmus</u>	735 Sligo Avenue Silver Spring, Md.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5277</u> DUE TO <u>Congestive heart failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cor pulmonale</u> 5 yrs. (c) <u>Pulmonary embolus</u> 15 yrs.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u>2</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>april 10, 1967</u> (County) <u>New Jersey</u> (State) <u></u>		
21. I certify that (1) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>64</u> , to <u>april 10, 1967</u> , that (1) (we) last saw the deceased alive on <u>Mar. 31 1967</u> , and that death occurred at <u>SP</u> M, from causes and on the date stated above.								
22a. SIGNATURE <u>James R. Coleman, M.D.</u>				22b. DATE SIGNED <u>4/10/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>James R. Coleman, M.D.</u>		22d. ADDRESS <u>9241 Columbia Blvd., Silver Spring, Md.</u>						
23a. BURIAL-CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>Apr 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Flower Hill Cemetery</u>		23d. LOCATION (City or Town) <u>North Bergen</u> (County) <u>New Jersey</u> (State) <u></u>		
24. FUNERAL DIRECTOR <u>Glen Carter</u>		ADDRESS <u>Glen Carter, 8434 Georgia Ave.</u>		25a. REC'D. BY REGISTRAR <u>APR 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
VR A15 (4) 20 M 1/66				DATE				

0231

THE CURE OF 1957

0231

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in one year, within 72 hours after death.

M

05280

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05278

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>DISTRICT OF COLUMBIA</b> <i>Be George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA (RURAL)</b>		c. LENGTH OF STAY IN 1b <b>3 HRS 16 MIN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NAVAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELEANOR</b>		First	Middle
4. DATE OF DEATH <b>APRIL 14, 1967</b>		Last	Month <b>APRIL</b> Doy <b>14</b> Year <b>1967</b>
S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>MALAYSIAN</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NA</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NA</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BETHESDA, MONTGOMERY, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>RUDOLFO Q. BANDONG</b>		14. MOTHER'S MAIDEN NAME <b>MARIA SARMIENTO</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NA NA</b>		16. SOCIAL SECURITY NO. <b>NA</b>	
17. INFORMANT APT: 301 WASHINGTON, D.C. <b>RUDOLFO Q. BANDONG, 5038 LIVINGSTON TERR. S.E.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive pulmonary atelectasis</b>		INTERVAL BETWEEN ONSET AND DEATH	
7680 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO	
DUE TO			
DUE TO			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>APRIL 14, 1967</b> , to <b>APRIL 14, 1967</b> , that <b>NA</b> (we) last saw the deceased alive on <b>APRIL 14, 1967</b> , and that death occurred at <b>0420AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Jerry J. Tomasovic</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>14 Apr. 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>Jerry J. Tomasovic, MD</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/18/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>ARLINGTON NATIONAL</b>
24. FUNERAL DIRECTOR W. W. CHAMBERS CO. <i>per seal</i> 1400 CHAPIN STREET, N.W., WASHINGTON, D.C.		25a. REC'D BY REGISTRAR DATE <b>APR 18 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

87820

02520

AT 0800Z 10 MAY 1968

VERBONOMY

1. TURKISH

2. M. AND P.

3. (LAW) LIBERTY

4. 2100Z 10 MAY 1968

5. 1000Z 11 MAY 1968

6. 1000Z

7. 0800Z

8. 0800Z

9. 0800Z 11 MAY

10. HALY/SH. 10 MAY

11. 0800Z 11 MAY 1968

12. 0800Z 12 MAY 1968

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27. 0800Z

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #8 infor. taken from birth cert.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT!

05281

05279

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN lb <i>Dec 6-9</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deerwood</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>117833 Cliftonne Lane</i>	
3. NAME OF DECEASED (Type or print) <i>Joseph</i>		First <i>J</i>	Middle <i>Bannon</i>
4. DATE OF DEATH <i>4-2-67</i>		Month <i>4</i>	Day Year <i>-2 1967</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>ogr</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED WIDOWER <input type="checkbox"/> DIVORCED DIVORCED
8. DATE OF BIRTH <i>Jan. 10, 1967</i>		9. AGE (In years last birthday) <i>2 mo.</i>	10. IF UNDER 1 YEAR Months <i>2</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John J. Bannon</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Haass</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Father-John J. Bannon</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia, bilateral, interstitial type</i>		INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>	
DUE TO <i>491X</i> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John G. Ball</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE THEREOF <i>4/5/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St Rose</i>
23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Ernest C. Gartner ADDRESS <i>Ernest C. Gartner Gaithersburg, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 7 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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Second

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05282

## CERTIFICATE OF DEATH

05280

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		b. COUNTY <b>Montgomery</b>			
c. LENGTH OF STAY IN lb <b>13 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban.</b>		d. STREET ADDRESS <b>1607 Grandin Ave</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>CLARENCE</b>	Middle <b>E</b>	Last <b>Bardsley</b>		
S. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-23-94</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>S.C.D.</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>N.Louis Mis</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Edward</b>		14. MOTHER'S MAIDEN NAME <b>Isabella Greg</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>173-20-3201</b>			
17. INFORMANT <b>Ruth A. Bardsley - Same above - Wife</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X Intracerebral Hemorrhage, right, spontaneous</b>					
DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause</b>					
(b) <b>Rupture right middle cerebral artery</b>					
DUE TO <b>Advanced cerebral arteriosclerosis</b>					
years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertensive Heart Disease</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>p.m.</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) <b>Chase</b> (County) <b>Missouri</b> (State) <b>Mo</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>April 24, 1967</b> to <b>April 24, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 24, 1967</b> , and that death occurred at <b>Chase</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>G. Bowditch Hunter Jr.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	DATE SIGNED <b>April 25, 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>G. Bowditch Hunter, Jr.</b>		22d. ADDRESS <b>50 W. Edmonston Drive, Rockville, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>		23b. DATE THEREOF <b>4/29/67</b>		23d. LOCATION (City or Town) <b>Rolla</b> (County) <b>Missouri</b> (State) <b>Mo</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		ADDRESS <b>1331 Rock. Pike</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
				DATE <b>APR 27 1967</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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05283

CERTIFICATE OF DEATH

05281

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

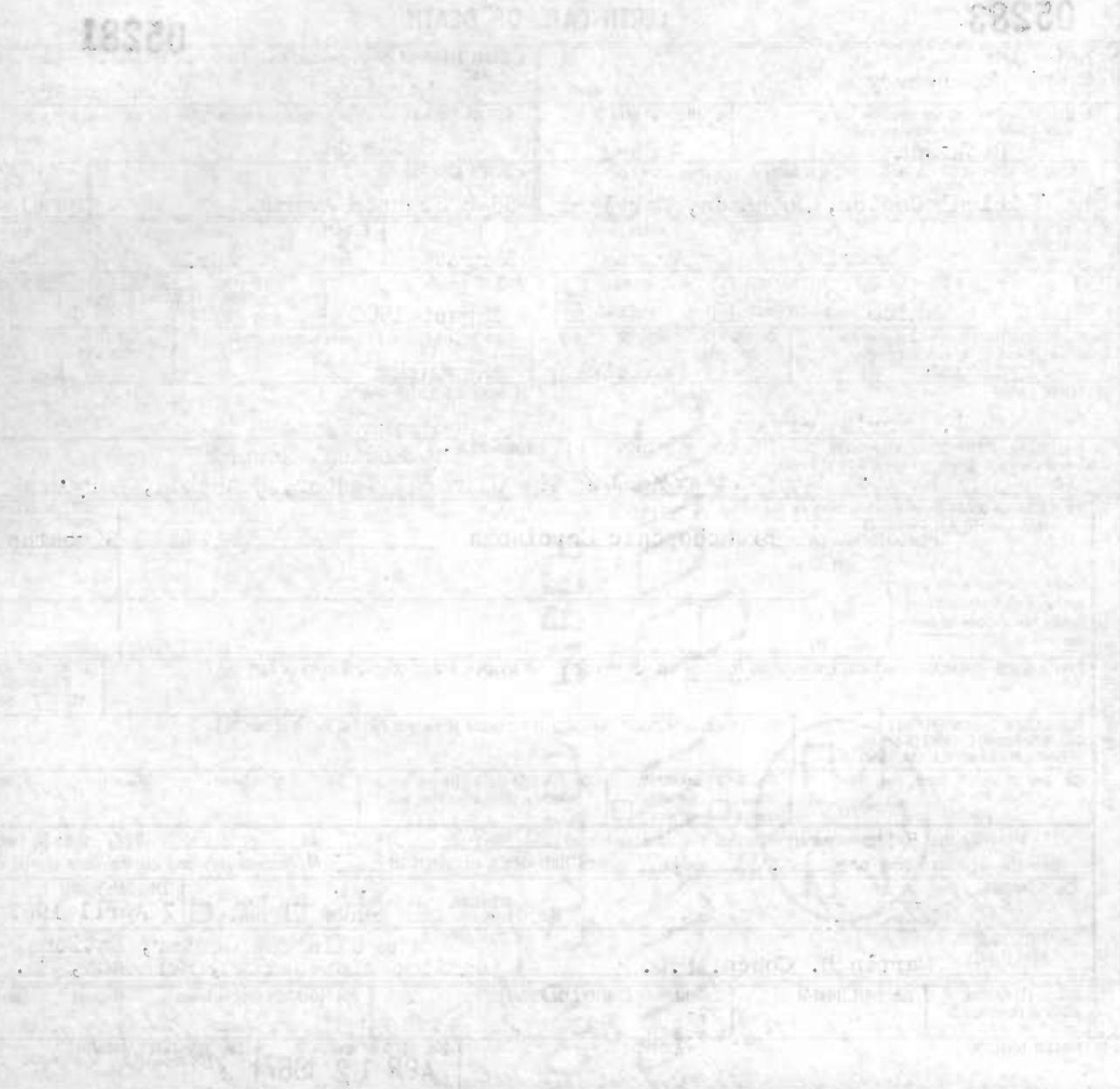
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN lb 9 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		d. STREET ADDRESS 5528 Johnson Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Morris	First Karlynn	Last Barrett	4. DATE OF DEATH Month April Day 6 Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 August 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Medicine	9. AGE (In years last birthday) 66 yrs.
10c. FATHER'S NAME J. Morris Barrett		11. BIRTHPLACE (County & State, or foreign country) Kentucky	
13. MOTHER'S MAIDEN NAME Thomasann Payne		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I & II		16. SOCIAL SECURITY NO. 216-44-6818	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621 Bronchogenic Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 5 months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		DUE TO DUE TO DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 28 March, 1967, to 6 April, 1967, that (I) (we) last saw the deceased alive on 6 April, 1967, and that death occurred at 6:25 M, from causes and on the date stated above.			
22a. SIGNATURE Martin H. Cohen		P.M. <input type="checkbox"/> M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 7 April 1967
22c. PHYSICIAN'S NAME (Type) Martin H. Cohen, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF APR. 8, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory
24. FUNERAL DIRECTOR Jos. Gavler's Sons, Inc. WASHINGTON, D.C.		ADDRESS	25a. RECEIVED BY REGISTRAR APR 12 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

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FOR STATE  
HEALTH DEPT.

05284

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05282

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSP.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ADELPHI</b>	
3. NAME OF DECEASED (Type or print) <b>LORRAINE GARNETT BARRY</b>		First	Middle	Last	4. DATE OF DEATH <b>APRIL 24 1967</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-1-23</b>	9. AGE (In years last birthday) <b>43 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>D.C.</b>	
13. FATHER'S NAME <b>HARTWELL SMITH</b>				14. MOTHER'S MAIDEN NAME <b>MARY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>ELAINE BARRY, AS ABOVE (DTR.)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute, severe, fatty metamorphosis</b>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>of liver</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>p.m.</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Princetown</b>	(County) <b>Prince George County</b> (State) <b>MD</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Belden R. Keap</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, Town or county) <b>Bellevue Hospital</b>		22. DATE SIGNED <b>4/24/1967</b>	
23a. BURIAL, CREMATION, REMOVAL(Specify) <b>burial</b>		23b. DATE THEREOF <b>4/28/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Cemetery</b>	23d. LOCATION (City or Town) <b>Princetown</b> (County) <b>Prince George County</b> , (State) <b>MD</b>	
24. FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.				25a. REC'D. BY REGISTRAR DATE <b>APR 26 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05285		CERTIFICATE OF DEATH						05283		
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b>				b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>37 Mins</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McLean</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>1244 Titania Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Henry Leidinheimer</b>		First <b>E</b> Middle	Last <b>Beardsley</b>	4. DATE OF DEATH <b>April 8 1967</b>		Month	Doy	Year		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 July 1914</b>		9. AGE (In years lost birthday) <b>52 yrs.</b>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USNavy</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>ACTIVE Duty</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Charles Harold Beardsley</b>			14. MOTHER'S MAIDEN NAME <b>Helen Gantt</b>			15. INFORMANT <b>Mrs. Virginia M. Beardsley</b>			Address <b>McLean, Va.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			17. SOCIAL SECURITY NO. <b>038 26 0576</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <i>4/20/1</i> DUE TO			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			(b) <b>Arteriosclerotic heart disease</b> DUE TO			(c)			Address <b>1244 Titania La</b>	
20. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <b>8 April 1967</b> , and that death occurred at <b>0637</b> M, fram causes and an the date stated above.			22b. DATE SIGNED <b>4/9/67</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>USNH, Bethesda, Md. 20014</b>		20f. (City or town) (County) (State)		
22a. SIGNATURE <i>Jack E. Zimmerman</i>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <b>Jack E. Zimmerman</b>			22d. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Private</b>			23b. DATE THEREOF <b>4/10/67</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers</b>			23c. NAME OF CEMETERY OR CREMATORIALy <b>Arlington National</b>			23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>			25a. REC'D. BY REGISTRAR DATE <b>APR 11 1967</b>	
ADDRESS <b>1400 Chapin St. NW, WDC</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 10 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMB, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #7 Film #G3814/2067 pc Item #3 Film #G3005/11701 pc MEDICAL EXAMINER'S CERTIFICATE OF DEATH												05287			
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>New York</i> b. COUNTY <i>Westchester</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Yankees</i>									
c. LENGTH OF STAY IN lb <i>D.02</i>						d. STREET ADDRESS <i>178 Kings Ave</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital -</i>						e. DATE OF DEATH Month <i>7</i> Day <i>8</i> Year <i>1967</i>									
3. NAME OF DECEASED (Type or print)		First <i>Steven</i>	Middle <i>Matthew</i>	Last <i>Benkovich</i>	4. DATE OF DEATH		Month <i>7</i>		Day <i>8</i>		Year <i>1967</i>				
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>July 25 1939</i>	9. AGE (In years last birthday) <i>27 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		11. IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>New York</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>					
13. FATHER'S NAME <i>Steven Benkovich</i>						14. MOTHER'S MAIDEN NAME <i>Anna Straub</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes, give war, or dates of service) <i>Marines</i>				16. SOCIAL SECURITY NO. <i>127-30-5536</i>		17. INFORMANT <i>Brother</i>		18. INFORMANT <i>Mr. Benkovich</i>		Address <i>Same as Item 2.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>8164</i> DUE TO <i>Contusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Heart</i> (c) <i>Automobile Accident</i>						INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Driving cart crashed into Auto Crossing highway at intersect</i>											
20c. TIME OF INJURY Month, Day, Year Hour <i>4:15</i> p.m. <i>4/8</i> 19 <i>67</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>Highway</i>		20f. (City or town) (County) (State) <i>Cherry Chase Montgomery Md</i>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>John G. Ball</i>		EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22. DATE SIGNED <i>4/9/67</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-11-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven PArk</i>		23d. LOCATION (City or town) (County) (State) <i>Valhalla Bronx N.Y.</i>							
24. FUNERAL DIRECTOR <i>Robert A. Humphrey, Bethesda, Md</i>		ADDRESS				25a. REC'D BY REGISTRAR <i>APR 13 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

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Water sample

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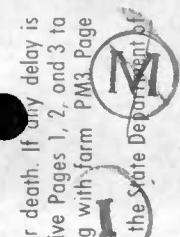
Exposure

Exposure time 347.67 minutes

Exposure time 347.67 minutes

Exposure

Exposure

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05287		MEDICAL EXAMINER'S CERTIFICATE OF DEATH					05288					
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>		c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>		d. STREET ADDRESS <i>7107 Connecticut Ave.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>7107 Connecticut Ave.</i>					d. STREET ADDRESS <i>7107 Connecticut Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Poutine</i>		First <i>N.</i>	Middle <i>Benton</i>	Last <i>Benton</i>	4. DATE OF DEATH <i>APRIL 16 1967</i>	Month <i>APRIL</i>	Doy <i>16</i>	Year <i>1967</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
S. SEX <i>Fe</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/23/31</i>			9. AGE (In years last birthday) <i>36 yrs.</i>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Biochemist</i>		10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Minnesota</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Victor Moll</i>					14. MOTHER'S MAIDEN NAME <i>Rachael - M. Perkins</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>			17. INFORMANT Husband Duane A. Benton		Address <i>Same as Item 2.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Pending - Barbiturate poisoning</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 hr. ?</i>				
971.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) <i>overdose of Tuinal and alcohol</i> DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Took overdose of Tuinal and alcohol</i>										
20c. TIME OF INJURY Month, Day, Year 2:30 Hour o.m. <i>4 16 67</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Chevy Chase Montg. Md.</i>						
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John G. Ball.</i>		M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED <i>4/16/67</i>				
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-19-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Rock Creek Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>						
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>			25a. REC'D BY REGISTRAR DATE <i>APR 24 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>						05289		
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WASH. D.C.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TACOMA PARK</b>			c. LENGTH OF STAY IN 1b 1b			b. COUNTY <b>R.D.N.W.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>"WASH. SAN. &amp; HOSP.</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASH. D.C.</b>		
3. NAME OF DECEASED (Type or print) <b>LAURA HENRY BLACK</b>			First	Middle	Last	4. DATE OF DEATH <b>APRIL 28 1967</b>	Month	Year
S. SEX <b>F.E.</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>10-22-76</b>	9. AGE (In years last birthday) <b>90 yrs.</b>	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>NORTH CAROLINA</b>		
13. FATHER'S NAME <b>William STETSON</b>			14. MOTHER'S MAIDEN NAME <b>Victoria Roberts</b>			12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.			17. INFORMANT <b>CHART</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4222</b> DUE TO <b>Possible Pulmonary embolism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arrhythmia, Atrial fibrillation</b> DUE TO <b>Myocardial hypertrophy + Dilatation</b> (c)								
INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>3</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/27/67</b> to <b>4/28/67</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>Chas H. Wolman</b>			M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Chas H. Wolman</b>			22d. ADDRESS <b>7401 Blair Rd NW</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5/2/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges County, Md.</b>		
24. FUNERAL DIRECTOR <b>Steffines Co 2901 14th NW DC</b>		ADDRESS		25a. RECD. BY REGISTRAR <b>MAY 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05283		05284	
<b>1. PLACE OF DEATH</b> a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN lb <i>3 days</i>		<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i> d. STREET ADDRESS <i>4005 Lawrence Ave</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> First <i>Kate</i> Middle <i>Copeland</i> Last <i>Bloomer</i> (Type or print)		<b>4. DATE OF DEATH</b> Month <i>April</i> Day <i>27</i> Year <i>1967</i>	
S. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/16/1886</i> 9. AGE (In years last birthday) <i>80 yrs.</i> IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Tenn.</i>	
12. FATHER'S NAME <i>Benjamin Copeland Seaton</i>		13. MOTHER'S MAIDEN NAME <i>Jane Gilbert Rebecca</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Yes</i>	
17. INFORMANT <i>odd some add. above, William J. Bloomer Jr. - Son.</i>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Coronary Arteriosclerosis &amp; Thrombosis</i> (b) DUE TO <i>3 days</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>Apr 26 1967</i> p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1967</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Apr 26 1967</i> to <i>Apr 27 1967</i> , that (I) (we) last saw the deceased alive on <i>Apr 26 1967</i> , and that death occurred at <i>1967</i> M, from causes and on the date stated above.		20f. (City or town) <i>Rockville</i> (County) <i>Maryland</i> (State) <i>Md.</i>	
22a. SIGNATURE <i>Robert T. Thibadeau</i>		22b. DATE SIGNED <i>Apr 27 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert T. Thibadeau</i>		22d. ADDRESS <i>Rockville, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr 29, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>
24. FUNERAL DIRECTOR <i>Glen Carter, Glen Carter, Warner E. Pumphrey, Inc.</i>		ADDRESS <i>18434 Georgia Avenue</i>	25d. REC'D BY REGISTRAR <i>MAY 1 1967</i>
		SILVER SPRING, MD.	25e. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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10 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10  
05290

CERTIFICATE OF DEATH

10  
05285

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the hospital or attending physician, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>26 days.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MAX LOUIS BLUM</i>		First	Middle
S. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>5-11-94</i>		9. AGE (In years lost birthday) <i>72 yrs.</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. GOVT General Services</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Russia</i>	
13. FATHER'S NAME <i>Gerson Blum</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> <i>No.</i>		16. SOCIAL SECURITY NO. <i>577-27-71854</i>	
17. INFORMANT <i>Medical Records.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Leukemia, lymphocytic, acute</i> DUE TO <i>2043</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Arteriosclerotic Cardio-vascular disease, congestive heart failure</i>		(b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic Cardio-vascular disease, congestive heart failure</i>			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3-20</i> , 19 <i>67</i> , to <i>4-15</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4-15</i> 19 <i>67</i> , and that death occurred at <i>4:25 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Eino Magi</i>		22b. DATE SIGNED <i>4-15-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>		22d. ADDRESS <i>831 University Blvd. E., Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-17-67</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>King David Mem.</i>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Holberg Funeral Home</i>		25a. REC'D BY REGISTRAR ADDRESS <i>4217-9th St., Ft. W.W.</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

02329

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5-2

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05291

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05286

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>Do A</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>12617 Epping Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Abraham</i>		First	Middle	Last	4. DATE OF DEATH <i>Barak</i>	Month	Year Apr 6 1967
S. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>7-13-89</i>	9. AGE (In years last birthday) <i>78</i>	IF UNDER 1 YEAR Months <i>yrs.</i>	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SELF EMPLOYED</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Fuel Oil</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>SOA J. BOCAK</i>		14. MOTHER'S MAIDEN NAME <i>MICHELE</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-56-8508</i>		17. INFORMANT <i>daughter Sarah (yaffee) Hegg-4028</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Coronary Insufficiency Acute</i>		DUE TO (b) <i>Cardio Vascular Disease</i>		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John G. Ball</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>JOHN G. BALL, M.D.</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county) <i>Hyattsville MD</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-7-67</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>GEO. L. WASH CEMETERY</i>		23d. LOCATION (City or Town) (County) (State) <i>Hyattsville MD</i>	
24. FUNERAL DIRECTOR <i>Good Bee Funeral Home</i>		ADDRESS <i>4217 9th St. NW</i>		25a. RECD BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
				DATE <i>APR 10 1967</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>														
<b>05292</b> 1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN lb. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FAIRLAND NRGH HOME 2101 FAIRLAND ROAD</b>						<b>05290</b> 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wyattsville D.C.</b> d. STREET ADDRESS <b>2214 Calvert Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED <small>(Type or print)</small>			First <b>FRANK</b>	Middle <b>BREITWIESER</b>	Last	4. DATE OF DEATH <b>APRIL 10 1967</b>			Month	Doy	Year			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-17-1892</b>		9. AGE (In years lost birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR <input type="checkbox"/> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUSINESSMAN Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>SALES man</b>				11. BIRTHPLACE (County & State, or foreign country) <b>HUNGARY</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>PHILIP BREITWIESER</b>			14. MOTHER'S MAIDEN NAME <b>Salome Pickenschiedt</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>177X</b>			16. SOCIAL SECURITY NO. <b>578-10-4321</b>			17. INFORMANT <b>Katherine Soule same as #2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, Heart Failure</b> DUE TO <b>177X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Metastatic Ca of Prostate</b> DUE TO (c)												12 mos.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. MEDICAL CERTIFICATION</b> ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)										
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>K5 NW. Wash. D.C.</b>		20f. (City or town) <b>K5 NW. Wash. D.C.</b> (County) <b>D.C.</b> (State)						
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 1966, to <b>Apr 10, 1967</b> , that (II) (we) last saw the deceased alive on <b>Mar 26 1967</b> , and that death occurred at <b>11:15 AM</b> , from causes and on the date stated above.														
22. SIGNATURE <b>James J. Foster</b>												22b. DATE SIGNED <b>4/10/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>James J. Foster</b>				22d. ADDRESS <b>1746 K5 NW. Wash. D.C.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4/13/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Cedar Hill Cemetery</b>				23d. LOCATION (City or Town) <b>Suitland, Md.</b> (County) <b>D.C.</b> (State)						
24. FUNERAL DIRECTOR <b>The S.H.W. Hines Co.</b> 2901 14th St. N.W. Washington, D.C.						25a. REC'D BY REGISTRAR <b>APR 13 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05293

CERTIFICATE OF DEATH

05291

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>17 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethesda Silver Spring Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First EDA Middle BOSE Last BREWER</b>		4. DATE OF DEATH <b>April 27, 1967</b>	
5. SEX <b>Female</b> 6. COLOR OR RACE <b>Cauc.</b>		7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <b>Nov. 14, 1892</b>		9. AGE (In years last birthday) <b>74 yrs.</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mass.</b>	
13. FATHER'S NAME <b>Herman Bose</b>		14. MOTHER'S MAIDEN NAME <b>Ida Beuhler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-20-1568</b>	
17. INFORMANT <b>Son</b> <b>Scott R. Brewer, Jr.</b>		7405 Ridgeway Ave. -Chevy Chase, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudofulbar Paroxysm</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Cerebral arteriosclerosis</b> DUE TO stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) <b>Arlington</b> (County) <b>Virginia</b> (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 1962</b> to <b>April 27, 1967</b> that (I) (we) last saw the deceased alive on <b>April 26, 1967</b> , and that death occurred at <b>6:05 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Robert N. Coale</b>		22b. DATE SIGNED <b>April 27, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT N. COALE</b>		22d. ADDRESS <b>4429 Bradley Lane, Chevy Chase, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-1-67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Natl Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 3 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
05294						05292								
1. PLACE OF DEATH a. COUNTY			MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE			Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Silver Spring			b. COUNTY			Montgomery					
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Takoma Park - 151					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			Sylvan Manor HEALTH CARE CENTER			d. STREET ADDRESS			318-Lincoln Ave					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print)			First MARY AVERETH MIDDLE BRIGGS			4. DATE OF DEATH			APR 18 1967					
5. SEX F			6. COLOR OR RACE W			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Dec. 11-1891 9. AGE (In years 75 yrs. last birthday)					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
At Home						Virginia								
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME											
Willie Vice Avereth			Mary Ella Sneed											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address					
						Nursing Home Records								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARINOMA TOSIS														
170X DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) CARCINOMA DUE TO (c) BREAST														
INTERVAL BETWEEN ONSET AND DEATH														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury In Part I or Part II of Item 18.)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED While Not While p.m. 19 at work at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from DEC. 21, 1966, to APR. 18, 1967, that (I) (we) last saw the deceased alive on APR. 18, 1967, and that death occurred at M, from the causes and on the date stated above.			22b. DATE SIGNED APR 18-1967											
22a. SIGNATURE Robert T. Thibadeau			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22c. PHYSICIAN'S NAME (Type) ROBERT T. THIBADEAU			22d. ADDRESS Rockville MD 20852											
23a. BURIAL CREMATION, REMOVAL (Specify) April 20, 1967			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR Esther Slaters						25a. REC'D BY REGISTRAR APR 21 1967			25b. REGISTRAR'S SIGNATURE Charles Judge					

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
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1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 160 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. STREET ADDRESS Box #44			
3. NAME OF DECEASED (Type or print) Yvonne Patricia Briscoe		4. DATE OF DEATH April 2 1967	
5. SEX Female Negro		6. COLOR OR RACE WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Briscoe		14. MOTHER'S MAIDEN NAME Carolyn Bowman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram Negative Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Acute Leukemia DUE TO (b) Acute Leukemia DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 1 Hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 24, 1966, to April 2, 1967, that (I) (we) last saw the deceased alive on April 2, 1967, and that death occurred at 2:25 M, from causes and on the date stated above.		22b. DATE SIGNED 3 April 1967	
22a. SIGNATURE William R. Lewis		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) William R. Lewis		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 5, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL ST. JOSEPHS		23d. LOCATION (City or Town) (County) (State) MORGANZA, ST. MARY'S, MO.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE APR 10 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. Dease	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
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<b>CERTIFICATE OF DEATH</b>											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b> , <b>16-2</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington San. + Hosp.</b>						d. STREET ADDRESS <b>3420 Chatham Road</b>					
3. NAME OF DECEASED (Type or print)		First <b>Jessie</b>	Middle <b>Eulala</b>	Last <b>Burke</b>	4. DATE OF DEATH <b>April 13 1967</b>		Month	Doy	Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-25-92</b>		9. AGE (In years last birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS. Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>				11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>			
13. FATHER'S NAME <b>Joel Fulton</b>				14. MOTHER'S MAIDEN NAME <b>Martha Vaughn</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure &amp; Uremia</b> <b>Second day</b> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1551</b> <b>Metastatic Carcinoma from pro bladder</b> <b>1 yr (Est)</b>											
DUE TO (b) <b>Chole lithiasis</b> <b>3 yrs</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>—</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1963</b>		20f. (City or town) <b>11/13</b> (County) <b>—</b> (State) <b>—</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> , 19 <b>—</b> , to <b>11/13</b> , 19 <b>67</b> , that (II) (we) lost saw the deceased alive on <b>4/13</b> 19 <b>67</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.											
22a. SIGNATURE <b>Raymond O West</b>											
22b. PHYSICIAN'S NAME (Type) <b>Raymond O West</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>April 13, 1967</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>April 16, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Kernersville Cemetery</b>		23d. LOCATION (City or Town) <b>Kernersville</b> (County) <b>Forsyth</b> (State) <b>N C</b>			
24. FUNERAL DIRECTOR <b>F. Gaschs Sons</b>				ADDRESS <b>Hyattsville, Md</b>		25a. REC'D BY REGISTRAR <b>APR 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05297

## CERTIFICATE OF DEATH

05295

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>26730 Ridge Rd.</b>		d. STREET ADDRESS <b>26730 Ridge Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Laura Gertrude Burns</b>		First <b>Laura</b>	Middle <b>Gertrude</b>
Last <b>Burns</b>		4. DATE OF DEATH <b>April 15</b>	Month Day Year 19 67
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <b>March 17, 1873</b>		9. AGE (In years last birthday) <b>94 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Purdum, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward King</b>		14. MOTHER'S MAIDEN NAME <b>Julia Burdette</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Aubrey Mullineaux, Item 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b>	
4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) <b>this hospital</b> attended the deceased from <b>2/10</b> , 19 <b>50</b> to <b>4/15</b> , 19 <b>67</b> that (I) <b>last saw the deceased alive on 4/11 1967</b> , and that death occurred at <b>2:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>James P. Kerr</b>		22b. DATE SIGNED <b>4/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>James P. Kerr, M.D.</b>		22d. ADDRESS <b>Damascus, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 17, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. View</b>
23d. LOCATION (City or Town) (County) (State) <b>Purdum, Md.</b>			
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>		ADDRESS	
25a. REG'D BY REGISTRAR <b>APR 19 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE			

02520

CHARGE TO OWNER

02520

Interpretation

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05298

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05296

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
<i>Montgomery Maryland</i>		<i>Mass. Suffolk</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Bethesda Md. D.O.A.</i>		<i>Hyde Park - Boston</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>Suburban</i>		<i>87 Wingate Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		58.3	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Francis Joseph Cameron</i>		<i>Francis</i>	<i>Joseph</i>
4. DATE OF DEATH		Month	Day
		4	22
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>m</i>		<i>gr</i>	<i>7-16-95</i>
8. DATE OF BIRTH		9. AGE (In years at time of death)	10. IF UNDER 1 YEAR Months Days Hours Min.
		<i>27</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
<i>Risked Draftsman U.S. Postals Sv. Mass.</i>		<i>Mass.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Thomas Cameron</i>		<i>Mary Finnegan</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>SON 026-18-7393 Ronald Cameron - Bethesda</i>	
17. INFORMANT		Address <i>4403 Chestnut St.</i>	
<i>son</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
<i>4222</i>		<i>2-2-67</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), due to (c),			
<i>Chronic Lymphocytic Leuk.</i>		<i>17 mo.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED	
ACTUAL SIGNATURE <i>John S. Rogers Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John S. Rogers Jr.</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <i>Worcester, Mass.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial-transit</i>		23b. DATE THEREOF <i>4-24-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>New Swedish Cemetery</i>
23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS	25a. REC'D BY REGISTRAR DATE <i>APR 28 1967</i>
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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11-16-12

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05293

## CERTIFICATE OF DEATH

05297

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington, D. C.</b>			b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			c. LENGTH OF STAY IN 1b <b>42 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>			d. STREET ADDRESS <b>1211 Kalmia Road, N. W.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Genevieve</b>			First <b>Elizabeth</b>	Middle <b>Carr</b>	Lost	4. DATE OF DEATH <b>April 24</b>	Month <b>1967</b>	Doy <b>67</b>	Year			
S. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan 27, 1907</b>	9. AGE (In years lost birthday) <b>60 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Frank P. Carr</b>						14. MOTHER'S MAIDEN NAME <b>Betsy G. Saffell</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>			16. SOCIAL SECURITY NO. <b>578-28-6017</b>			17. INFORMANT <b>Mrs. Frank Carr</b>			Address <b>1211 Kalmia Road, N.W. Washington, D. C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4341</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Congestive Heart Failure</b> (c) <b>Congenital Heart disease</b>						<b>TERMINAL PULMONARY EDEMA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									3 mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1-28</b>			20f. (City or town) (County) (State) <b>4/23</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>4/23</b> , 1967, to <b>4/23</b> , 1967, that (I) (we) last saw the deceased alive on <b>4/23</b> , 1967, and that death occurred at <b>4/23</b> M, from causes and on the date stated above.												
22a. SIGNATURE <b>Francis X. Richardson</b>									22b. DATE SIGNED <b>4/24/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Francis X. Richardson, M. D.</b>			22d. ADDRESS <b>11412 Viers Mill Road, Wheaton, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Apr 26, 1967</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>			
24. FUNERAL DIRECTOR <b>John B. Thomas, Jr., Thomas &amp; Warner, Inc.</b>			ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>			25a. REC'D BY REGISTRAR <b>APR 27 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles J. Geiger</b>			

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02580

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #9 Film #G388 4/26/67 pc

05300

## CERTIFICATE OF DEATH

05298

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Montgomery</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deceased</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Saberton</i>			d. STREET ADDRESS <i>10500 Old Georgetown Rd</i>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Samuel E. Carter</i>		First <i>Samuel</i>	Middle <i>E.</i>	Last <i>Carter</i>	4. DATE OF DEATH <i>April 20 1967</i>	Month <i>April</i>	Day <i>20</i>	Year <i>1967</i>		
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH <i>9/7/09</i>	9. AGE (in years last birthday) <i>57 1/2 yrs.</i>	IF UNDER 1 YEAR Months <i>15</i>	IF UNDER 24 HRS. Days <i>15</i>	Hours <i>15</i>	Min. <i>15</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Horace Carter</i>			14. MOTHER'S MAIDEN NAME <i>Bessie</i>			Address <i>Wife Gerredine (Same as above)</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>578-44-5226</i>			17. INFORMANT <i>Wife Gerredine (Same as above)</i>			18. INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>atherosclerosis</i> DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Essential hypertension</i>										
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>4/20 1967</i>							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>809 Veirs Mill Rd Rockville Md</i>		20f. (City or town) (County) (State) <i>Rockville Gaithersburg Maryland</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>1963</i> , 19 to <i>4-20</i> , 1967, that (I) (we) lost saw the deceased alive on <i>4-20 1963</i> , and that death occurred at <i>110 M</i> , from causes and on the date stated above.			22b. DATE SIGNED <i>4-20-67</i>							
22a. SIGNATURE <i>Donald L Bucy</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <i>Donald L Bucy</i>			22d. ADDRESS <i>809 Veirs Mill Rd Rockville Md</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>4/22/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Forest Oak</i>		23d. LOCATION (City or Town) (County) (State) <i>Gaithersburg Maryland</i>			
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>			ADDRESS <i>1331 Rock. Pike Rockville, Md.</i>		25a. REC'D BY REGISTRAR <i>APR 24 1967</i>		25b. REGISTRAR'S SIGNATURE <i>for me</i>			
VR A15 (4) 25M 1/67										

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2b, c &amp; d Film #G388 5/8/67

05301

## CERTIFICATE OF DEATH

05299

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		b. COUNTY <i>Montgomery / Balto.</i>	
c. LENGTH OF STAY IN 1b <i>Wheaton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton / Balto.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wheaton Nursing Home</i>		d. STREET ADDRESS <i>4608 Roland Ave 11801 G St N.W., Washington, Md.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>MARY</i>	Middle <i>ROBERTA</i>	Last <i>CHASE</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <i>11-2-1866</i>	9. AGE (In years last birthday) <i>100 yrs.</i>	IF UNDER 1 YEAR Months <i>5325</i>	IF UNDER 24 HRS. Days <i>Adatkertowne Rd.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>William Jefferis Barnes</i>	14. MOTHER'S MAIDEN NAME <i>Ruth Anna Beans</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs. Myra E. Lank</i>	5325 Adatkertowne Rd. Washington, D. C.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Coronary occlusion</i> 4201 DUE TO <i>Serial Generalized Arteriosclerosis</i> 1 hour Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Serial Generalized Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carcinoma Vulva</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) (County) (State) <i>—</i>
21. I certify that (I) (this hospital) attended the deceased from <i>4-17, 1967</i> , to <i>4-27, 1967</i> , that (I) (we) last saw the deceased alive on <i>4-26, 1967</i> , and that death occurred at <i>9:30 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>P.P. Andrews</i>		22b. DATE SIGNED <i>4-27-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>P.P. Andrews M.D.</i>	22d. ADDRESS <i>WASHINGTON, DC</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5/1/1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Friends Burial Grounds</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>
24. FUNERAL DIRECTOR <i>Wm. J. Jenkins &amp; Sons Mortuary</i>	ADDRESS <i>1001 Park Ave., Baltimore, Md.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 11, 13 & 14 Film G390 7/18/67 kk

05302

CERTIFICATE OF DEATH

05300

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Tennessee</b> b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>4 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Memphis</b> 79.8						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>			d. STREET ADDRESS <b>3986 Weaver Road</b>						
3. NAME OF DECEASED (Type or print) <b>Calvin M. CHAVIES</b>			First <b>Calvin</b>	Middle <b>M.</b>	Last <b>CHAVIES</b>				
4. DATE OF DEATH <b>April 11 1967</b>	Month <b>April</b>	Day <b>11</b>	Year <b>1967</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
S. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>November 12, 1912</b>	9. AGE (In years last birthday) yrs. <b>54</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Unknown Dawson Springs, Ky.</b>	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME <b>Unknown Calvin Hunsaker</b>			14. MOTHER'S MAIDEN NAME <b>Unknown Rose Ferrell</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT <b>Memphis</b>	Address <b>Tennessee</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarct</b>			INTERVAL BETWEEN ONSET AND DEATH						
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatic aortic stenosis</b>									
DUE TO (b) <b>Rheumatic aortic stenosis</b>									
DUE TO (c) <b></b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) <b></b>	(County) <b></b>	(State) <b></b>		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 7, 1967</b> , to <b>April 11, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 11, 1967</b> , and that death occurred at <b>815A M</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>David R. Foreman</b>			22b. DATE SIGNED <b>Apr. 13, 1967</b>						
22c. PHYSICIAN'S NAME (Type) <b>David R. FOREMAN, M. D.</b>			22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-14-1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Rock Creek Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>					
24. FUNERAL DIRECTOR Joseph Gawler & Sons ADDRESS <b>5130 Wisconsin Ave., Washington, D. C. N.W.</b>			25a. REC'D BY REGISTRAR <b>DATA APR 20 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT

05303

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05301

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Or. Geo.</i>	
c. LENGTH OF STAY IN lb <i>D.o.b.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash. San + Hospital</i>		d. STREET ADDRESS <i>7603 - 15th ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>James Taylor Chewning</i>		First <i>J</i>	Middle <i>T</i>
		Last <i>Chewning</i>	
4. DATE OF DEATH Month <i>4</i>		Month <i>Month</i>	Day <i>15</i>
		Year <i>1967</i>	Year <i>Year</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>11-17-46</i>		9. AGE (In years last birthday) <i>20 yrs.</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk at G.P.O.</i>		11. BIRTHPLACE (State or foreign country) <i>D.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Lester M. Chewning</i>		14. MOTHER'S MAIDEN NAME <i>Mary Wynkoop</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Lester Chewning</i>		Address <i>7603 15th Avenue Takoma Park, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>82311</i>		INTERVAL BETWEEN ONSET AND DEATH <i>SUDDEN</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO TRAUMA FROM AUTO ACCIDENT			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Passenger in car... went out of control struck Bob</i>	
20c. TIME OF INJURY Month, Day, Year <i>1:35 p.m. 4/15 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) (County) (State) <i>Adelphi Prince George's Md.</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John G. Ball</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <i>7936 Old Georgetown Rd. Bethesda, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr 19, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co., Md.</i>	
24. FUNERAL DIRECTOR <i>Glen Carter</i>		ADDRESS <i>8434 Georgia Avenue Warren E. Pumphrey, Inc. Silver Spring, Md.</i>	
25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**NO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

NOVATECH MEDICAL INC.

05304

## **CERTIFICATE OF DEATH**

05302

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>CALIFORNIA</b> b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>		c. LENGTH OF STAY IN lb <b>2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUNLAND</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Valley Nursing Home</b>			d. STREET ADDRESS <b>7948 Wentworth Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>MERCELIA</b>		First <b>MERCELIA</b>	Middle <b>CHINO</b>	Last <b>CHINO</b>	4. DATE OF DEATH <b>April 28 1967</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>August 9, 1888</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Year Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Thomas E. Hicks</b>			14. MOTHER'S MAIDEN NAME <b>Tda E. Scofield</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>325-09-5392</b>		17. INFORMANT <b>Elbert Chino (son)</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b>			DUE TO (b) <b>CEREBROVASCULAR ACCIDENT</b>		DUE TO (c) <b>ARTERIOSCLEROSIS. GENERAL</b>		INTERVAL BETWEEN ONSET AND DEATH <b>40 DAYS</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>33IX</b>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>2/26/67</b> , 19 <b>to 4/28/67</b> , 19, that (I) (we) last saw the deceased alive on <b>4/24/67</b> , 19, and that death occurred at <b>8:45 AM</b> , from causes and on the date stated above										
22a. SIGNATURE <b>Ronald W. Barr</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>RONALD W. BARR, M.D.</b>			22d. ADDRESS <b>10401 Old Georgetown Rd Bethesda, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>4/28/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Lee's Crematorium</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>				
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>			ADDRESS <b>Washington, D. C.</b>		25a. REC'D BY REGISTRAR <b>MAY 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Items 18&21 Film 390 6-2 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
05305				05303							
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY					
c. LENGTH OF STAY IN lb <i>Washington</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>1374 Taylor St. N.W.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash San + Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First <i>Antonio</i>	Middle <i>Chite</i>	Last <i>Chite</i>	4. DATE OF DEATH Month <i>4</i>			Doy <i>3</i>	Year <i>1967</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED WIDOWED <input type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-7-83</i>		9. AGE (In years at birthday) <i>83</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shoemaker</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>				11. BIRTHPLACE (State or foreign country) <i>Italy</i>			
13. FATHER'S NAME <i>Carmelo Chite</i>				14. MOTHER'S MAIDEN NAME <i>Carmela</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No				16. SOCIAL SECURITY NO. <i>577-48-0896</i>				17. INFORMANT <i>Hospital Record.</i> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute bronchopneumonia, Bilateral</i> INTERVAL BETWEEN ONSET AND DEATH 491X DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Belden B. Reap</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <i>BELDEN B. REAP, M.D.</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>4-6-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Mary's Cemetery</i>		23d. LOCATION (City or town) (County) (State) <i>Washington, D. C.</i>			
24. FUNERAL DIRECTOR <i>Francis J. Collins</i>				ADDRESS <i>3821-14th St. NW Wash DC</i>		25a. REC'D BY REGISTRAR <i>APR 7</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05306

CERTIFICATE OF DEATH

05304

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Rapp.

Cleared & medical examiner.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tahoma Park</u>		c. LENGTH OF STAY IN lb <u>2 hours</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. STREET ADDRESS <u>923 Langley Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Bertha</u>		First	Middle	4. DATE OF DEATH Year	Month	Doy	Year										
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-93</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>South Dakota</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>								
13. FATHER'S NAME <u>James Ford</u>			14. MOTHER'S MAIDEN NAME <u>Adema Dunn</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>578-10-9651</u>								
17. INFORMANT <u>Records - Washington Sanitarium + Hospital</u>			Address			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1998</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>66</u> , to <u>April 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 24, 1967</u> , and that death occurred at <u>4:55 PM</u> , from causes and on the date stated above.			22a. SIGNATURE <u>John N. Andrews</u>			22b. DATE SIGNED <u>Apr. 24-67</u>											
22c. PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>			22d. ADDRESS <u>9601 Colesville Rd Silver Spring Md</u>			23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE THEREOF <u>4/28/67</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Glenwood Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>		
24. FUNERAL DIRECTOR <u>The S. J. Kline Co. 2901-14th St. Washington D.C.</u>			ADDRESS <u>Washington D.C.</u>			25a. REC'D BY REGISTRAR DATE <u>APR 27 1967</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

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10-28-40 1230PM

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05307

## CERTIFICATE OF DEATH

05305

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>DIST. OF Col.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>8700 Jones Mill Road</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WASHINGTON,</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bethesda - Silver Spring Nurs. Home</i>		d. STREET ADDRESS <i>8421 Hawthorne St. N.W. 8700 Jones Mill Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Kathryn Jones Clark</i>		First <i>Kathryn</i>	Middle <i>Jones</i>
3. NAME OF DECEASED (Type or print) <i>Kathryn Jones Clark</i>		Lost. <input type="checkbox"/>	4. DATE OF DEATH Month Day Year <i>4 - 9 - 1967</i>
S. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>1-15-87</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>- - -</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>- - -</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Jersey City</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Albert Jones</i>	14. MOTHER'S MAIDEN NAME <i>Anna Jones</i>	Address <i>See Item #2.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>- - -</i>	16. SOCIAL SECURITY NO. <i>- - -</i>	17. INFORMANT <i>G. Edward Clark (Son)</i>	18. INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> DUE TO <i>4200</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1966</i> to <i>9/9 1967</i> , that (I) (we) last saw the deceased alive on <i>4/9 1967</i> , and that death occurred at <i>9/9 1967</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>G. Leonard Gold</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>4/9 1967</i>
22c. PHYSICIAN'S NAME (Type) <i>G. Leonard Gold</i>		22d. ADDRESS <i>8641 - Colesville Rd. Silver Sp. Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify Removal)	23b. DATE THEREOF <i>4-12-1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Brick Church Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Montgomery, N.Y.</i>
24. FUNERAL DIRECTOR <i>Gawler's</i>	ADDRESS <i>Wisconsin</i>	25a. REC'D BY REGISTRAR DATE <i>APR 12 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and intact, within 72 hours after death.

CERTIFICATE OF DEATH		05306	
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN lb <u>6 mo - 20 da.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) d. STATE <u>MD.</u> e. COUNTY <u>Towson</u> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> , 151 g. STREET ADDRESS <u>104 Cedar ave.</u> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGUERITE</u> First <u>N.</u> Middle <u></u> Last <u>CLEMENTS</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Mar 7-1890</u>		9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Troy, Mich.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Silas Miles</u>	
14. MOTHER'S MAIDEN NAME <u>Alice B. Foote</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. John W. Griffith, Gaithersburg</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>332X</u> DUE TO <u>cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO <u>cerebral atherosclerosis</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) <u>Gaithersburg</u> (County) <u>Montgomery</u> (State) <u>MD</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>9-19</u> , 19 <u>63</u> to <u>4-7</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>3-14</u> 19 <u>62</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above.		22b. DATE SIGNED <u>4-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D.L. Bucy - S.N. Jones</u>		22d. ADDRESS <u>809 Veirs Mill Rd Rockville MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		23b. DATE THEREOF <u>4-10-76</u>	
23c. NAME OF CEMETERY OR CREMATORIAL <u>Forest Glen</u>		23d. LOCATION (City or Town) <u>Gaithersburg</u> (County) <u>Montgomery</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>		25a. RECEIVED BY REGISTRAR <u>John Charles Judge</u> DATE <u>APR 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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5309

CERTIFICATE OF DEATH

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5307

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>20 days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		e. STREET ADDRESS <b>8105 Eastern Avenue</b>		
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Bertram Jay Cohen</b>		First <b>Bertram</b>	Middle <b>Jay</b>	
4. DATE OF DEATH <b>April 29 1967</b>	Month <b>April</b>	Day <b>29</b>	Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 25, 1942</b>	
9. AGE (In years last birthday) <b>24 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Interviewer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Employment</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jack Cohen</b>		14. MOTHER'S MAIDEN NAME <b>Florence Waxman</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-40-7826</b>	17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>40 minutes</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>2001</b>		DUE TO (b) <b>Lymphosarcoma</b> DUE TO (c)		
1 year				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>I</b> (this hospital) attended the deceased from <b>April 9, 1967</b> , to <b>April 29, 1967</b> , that <b>I</b> (we) last saw the deceased alive on <b>April 29, 1967</b> , and that death occurred at <b>11:40M</b> , from causes and on the date stated above.				
22a. SIGNATURE <b>Leonard H. Brubaker</b>		P.M. <input type="checkbox"/> MED. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>April 30, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leonard H. Brubaker, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4/30/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>King David Mem. Gar.</b>	23d. LOCATION (City or Town) (County) (State) <b>Falls Ch., Virginia</b>
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b>		ADDRESS <b>3501-14th St. NW, Wash. DC, 20010</b> REC'D BY REGISTRAR <b>MAY 2 1967</b> REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05310

CERTIFICATE OF DEATH

05308

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>VIRGINIA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA (rural)</b>		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NAVAL HOSPITAL</b>	
e. NAME OF DECEASED (Type or print) <b>VINCENT X WILLIAM</b>		f. STREET ADDRESS <b>1108 PALMER PLACE</b>	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <b>X</b> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 MAY 1967 1921</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US NAVY</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>LYNCHBURG, VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EDWARD RANDOLPH COLLINS</b>		14. MOTHER'S MAIDEN NAME <b>ELLA WILLIAMS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> <i>Active</i>		16. SOCIAL SECURITY NO. <b>229 03 3421</b>	
17. INFORMANT <b>CAROL M. COLLINS</b>		18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>CARDIAC ARREST</b>	
4330 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost.		DUE TO (b) DUE TO (c)	
19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>p.m.</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>NAVAL HOSPITAL</b>		(County) <b>ALEXANDRIA, VIRGINIA</b>	
20g. (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>21 APRIL 1967</b> , to <b>21 APRIL 1967</b> , that (I) (we) last saw the deceased alive on <b>21 APRIL 1967</b> , and that death occurred at <b>5:40 AM</b> causes and on the date stated above.		22b. DATE SIGNED <b>21 APRIL 1967</b>	
22a. SIGNATURE <i>H. Rivas</i>		22b. ADDRESS <b>CDR MC USN</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. RIVAS</b>		22d. ADDRESS <b>NAVAL HOSPITAL</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/24/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Pine Crest Gardens</b>
23d. LOCATION (City or Town) <b>MARIANNA, FLORIDA</b>		(County) <b>Florida</b>	
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO.</b>		(State)	
ADDRESS <b>1400 CHAPIN ST. NW WASHINGTON, D.C.</b>		25a. REG'D BY REGISTRAR <b>APR 25 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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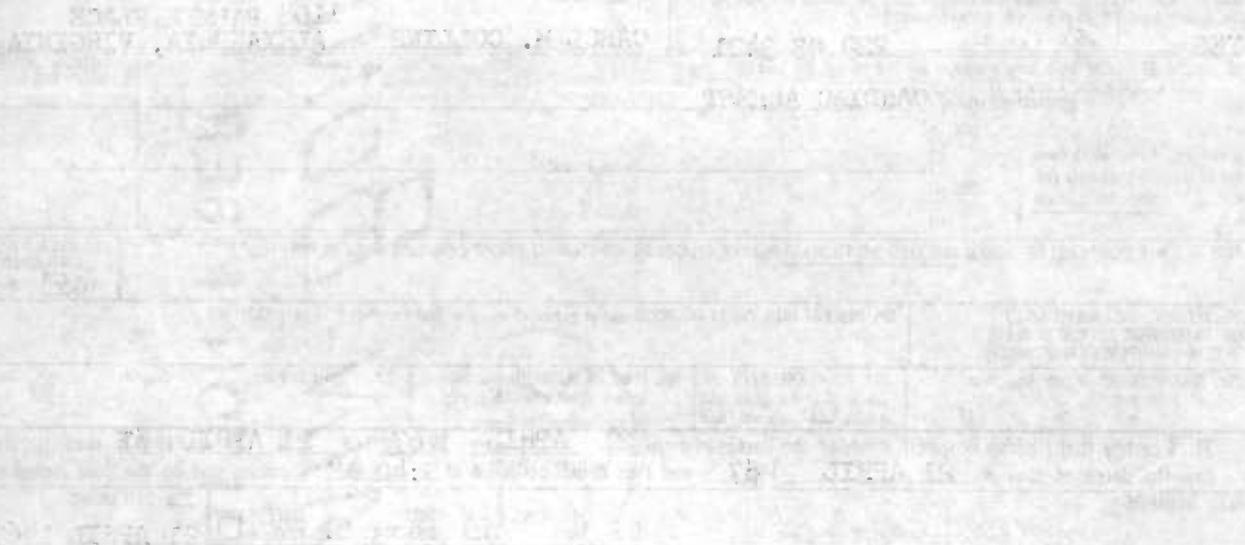
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

05311

**CERTIFICATE OF DEATH**

05309

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Potomac Valley Nursing Home</i>		e. STREET ADDRESS Box 76 (20767)		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Clara</i>		First <i>P.</i>	Middle <i>Connable</i>	Last <i>April</i>	4. DATE OF DEATH Month <i>6</i> Day <i>1967</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>March 22, 1880</i>	9. AGE (In years last birthday) <i>87 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Chicago, Illinois</i>	
13. FATHER'S NAME <i>Frank Patterson</i>		14. MOTHER'S MAIDEN NAME <i>Annie Ryan</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>219 54 5206T</i>		17. INFORMANT Address <i>Margaret G. Riggs - Daughter- same #2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tremia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Sclerotic nephritis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
(b) DUE TO <i>Arterio sclerosis</i>				<i>10 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Obstruction</i> <i>Jaundice</i>				<i>20 yrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>30 March 1967</i> to <i>6 April 1967</i> that (I) (we) last saw the deceased alive on <i>30 April 1967</i> , and that death occurred at <i>6:20 AM</i> from causes and on the date stated above.					
22a. SIGNATURE <i>W. Murphy</i>				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>William S. Murphy</i>		22d. ADDRESS <i>615 W. Montgomery Ave., Rockville Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>4/6/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		ADDRESS <i>1331 Rock. Pike Rockville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 7 1967</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05312

CERTIFICATE OF DEATH

05310

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Garde Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Margory Ann Contant		d. STREET ADDRESS 130 G.A. Windsor Mill Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>
		8. NEVER MARRIED <input type="checkbox"/>	9. DIVORCED <input type="checkbox"/>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Stack		14. MOTHER'S MAIDEN NAME Frances Patton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetes mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH	
260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour: o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (This Hospital) attended the deceased from <i>Mar 18</i> , 1966, to <i>April 21</i> , 1967, that (I) (we) last saw the deceased alive on <i>April 21</i> , 1967, and that death occurred at 5:20 P.M., from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE <i>H F Kreuzburg</i>		22b. DATE SIGNED <i>4/21/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>H F Kreuzburg</i>		22d. ADDRESS <i>2852 16th NW Washington D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF April 22, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery
23d. LOCATION (City or Town) Suitland Md.		(County) (State)	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Md.		25a. ADDRESS Robert E. Wilhelm Funeral Home 4308 Suitland Md.	25b. REG'D BY REGISTRAR DATE APR 25 1967
		REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05311

05313

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Pr. Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb <b>1-½ hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W. Hyattsville</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>5601 Parkerhouse Terr</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
18. NAME OF DECEASED (Type or print) <b>Robert</b>		First	Middle <b>NMT</b>	Lost	4. DATE OF DEATH <b>Contino</b>	Month <b>4</b>	Day <b>2</b>	Year <b>1967</b>	
S. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH <b>Feb 26, 1897</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Timekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotels</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Brooklyn, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b> <b>WWI - Army</b>		16. SOCIAL SECURITY NO. <b>577 26 8283</b>		17. INFORMANT <b>Adm. 101, Parkerhouse Terrace, W. Hyattsville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b>		Causes of death <b>Coronary artery insufficiency</b>						Known <b>1 yr</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b>									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , to <b>April 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 2, 1967</b> , and that death occurred at <b>4109 M. Street</b> , from causes and on the date stated above.								22b. DATE SIGNED <b>April 2, 1967</b>	
22a. SIGNATURE <b>Aaron H. Traum</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.							
22c. PHYSICIAN'S NAME (Type) <b>AARON H. TRAUM, M.D.</b>		22d. ADDRESS <b>8237 Georgia Ave - Silver Spring, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 7, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Alexandria National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Alexandria, Virginia</b>			
24. FUNERAL DIRECTOR <b>John B. Thomas, Thomas Funeral Home, Inc.</b>		ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

02911

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05314

05312

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Montgomery				e. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY Montgomery	
Kenwood				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		5415 Dorset Ave		Kenwood	
e. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Female		Ona	Gibson	Cooper	Month Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 83 yrs.
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 6, 1884	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
Housewife				Kansas	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Robert J. Gibson		Ella Banks		U. S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-52-2208		17. INFORMANT Son Kenneth B. Cooper	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Astroscopic Cardiac Vasculitis Disease</i>		INTERVAL BETWEEN ONSET AND DEATH 2 yrs t	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) } DUE TO					
{ (c) } DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input type="checkbox"/> p.m. 19		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20l. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1964, 19, to 4-4, 1967 that (I) (was) last saw the deceased alive on 4-3, 1967, and that death occurred at 8 A.M. from the causes and on the date stated above.					
22a. SIGNATURE <i>George R. Huffman</i>					
22c. PHYSICIAN'S NAME (Type)		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> APR. 4, 1967	
GEORGE R. HUFFMAN				22d. ADDRESS 2401 - Calvert St. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-6-67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington Nat'l Gem.	
24 FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR APR 10 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05315

Items #2b &amp; 7 Film #G387 1/20/67 pc

## CERTIFICATE OF DEATH

05313

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN lb <b>21 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. STREET ADDRESS <b>1028 UNIVERSITY BLVD.</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mrs. ESTHER C. CORRIGAN</b>		First	Middle
4. DATE OF DEATH Month <b>APRIL</b>	Day <b>9</b>	Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>1-16-1900</b>	9. AGE (In years last birthday) <b>67 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper Govt. Printing Office U.S. Govt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
10c. FATHER'S NAME <b>Howard Webster Foxwell</b>		10d. MOTHER'S MAIDEN NAME <b>Hattie M. Foxwell</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		14. SOCIAL SECURITY NO. <b>215-44-8543</b>	
15. INFORMANT <b>Helen J. Campbell</b>		16. ADDRESS <b>1028 University Blvd. Silver Spring, Md.</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>INANITION</b>		18. INTERVAL BETWEEN DEATH AND DEATH <b>1530</b>	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause <b>1530</b>		DUE TO (b) <b>METASTATIC CARCINOMA</b>	
		DUE TO (c) <b>CARCINOMA CECUM</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>67</b> , to <b>APR 9, 1967</b> , that (I) (we) last saw the deceased alive on <b>APR 9, 1967</b> , and that death occurred at <b>12:30 P.M.</b> , from causes and on the date stated above.		22. SIGNATURE <b>Leonard L. Deitz</b>	
22a. PHYSICIAN'S NAME (Type) <b>LEONARD L. DEITZ</b>		22b. DATE SIGNED <b>Apr 10 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 12, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>	
24. FUNERAL DIRECTOR <b>J. Glen Carter</b> Carter Caskets 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.		25a. ADDRESS <b>1106 Spring St. S.S., Mont., Md.</b>	
25b. REC'D BY REGISTRAR <b>APR 13 1967</b>		25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

61630

10

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**PAGE 4** may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05316

**CERTIFICATE OF DEATH**

05314

1. PLACE OF DEATH <b>Wheaton Montgomery Maryland</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>a. STATE Maryland b. COUNTY Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. LENGTH OF STAY IN lb <b>10½ years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		d. STREET ADDRESS <b>2100 Arcola Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2100 Arcola Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Robert</b>		First <b>Humphreys</b>	Middle <b>Cox</b>	4. DATE OF DEATH <b>April</b>	Month <b>16</b>	Doy <b>19</b>	Year <b>67</b>
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 2, 1906</b>	9. AGE (In years lost birthday) yrs. <b>60</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Walter Truland Corp.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Davidsonville, Md.</b>		
13. FATHER'S NAME <b>James Thomas Cox</b>				14. MOTHER'S MAIDEN NAME <b>May E. Humphreys</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>				16. SOCIAL SECURITY NO. <b>578-03-2084</b>		17. INFORMANT <b>Nellie U. Cox</b> Address <b>2100 Arcola Avenue Wheaton, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO <b>Coronary Occlusion</b> 1 day <b>Coronary Arteries Occlusion</b> 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Essential Hypertension</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1, 1965</b> , to <b>April 16, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 16, 1967</b> and that death occurred at <b>7A M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>John J. Curry</b>				22b. DATE SIGNED <b>4/16/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>John J. Curry</b>		22d. ADDRESS <b>10620 Georgia Ave Silver Spring</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 19, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Snitzland, Maryland</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas &amp; Sons Inc.</b>		ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MECC

MADE IN JAPAN

31530

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**05317**

**CERTIFICATE OF DEATH**

**05315**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	c. LENGTH OF STAY IN lb <b>36 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McLean</b>	d. STREET ADDRESS <b>7804 Timon Drive</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Keith</b>	Middle <b>Charles</b>	Last <b>Culp</b>
4. DATE OF DEATH <b>April 15 1967</b>	Month Day Year		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>May 26, 1962</b>	9. AGE (In years last birthday) <b>4 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Minutes
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Joe C. Culp</b>	14. MOTHER'S MAIDEN NAME <b>Norma C. Kennan</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT The Medical Record's Address <b>The Clinical Center, Bethesda, Maryland 20014</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable septicemia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO (c) <b>Acute Lymphatic Leukemia</b> DUE TO			2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>March 10, 1967</b> , to <b>April 15, 1967</b> , that <b>10</b> (we) last saw the deceased alive on <b>April 15, 1967</b> , and that death occurred at <b>9:50</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Myron J. Levin</i>	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>16 April 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>Myron J. Levin, MD</b>	22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 19, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Pine Crest</b>	23d. LOCATION (City or Town) (County) (State) <b>Little Rock, Arkansas</b>
24. FUNERAL DIRECTOR <i>Mac P. Rosen</i>	ADDRESS <b>9901 N. Fairfax</b>	REC'D BY REGISTRAR <b>APR 19 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles George</i>
Arlington Funeral Home		Arlington, Va.	

2166

RECORD TO TRADE

11022

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

05318

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05316

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <b>Carl</b> Middle <b>E.</b> Surname <b>Cummins</b> (Type or print)		4. DATE OF DEATH Month <b>24</b> , Day <b>April</b> , Year <b>1967</b>	
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1914</b> 9. AGE (In years lost birthday) <b>52</b> yrs. <b>28, Apr.</b> <b>1967</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Major - U.S.A. retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	
11. BIRTHPLACE (State or foreign country) <b>Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James E. Cummins (Decd)</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ingweisen (Decd)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>WW II</b>		16. SOCIAL SECURITY NO. <b>579-52-6461</b> 17. INFORMANT <b>Maryon Lucille Cummins 2005 Cascade St. Silver Spring</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Acute myocardial Disease</b> DUE TO <b>the 31</b> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Arlington</b> (County) <b>Virginia</b> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>4-24-67</b>	
ACTUAL SIGNATURE <i>John S. Rogers Jr.</i> EXAMINER'S NAME (Type) <b>John S. Rogers Jr. MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> (Address, street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 28, 1967</b> 23c. NAME OF CEMETERY OR Crematory <b>Arlington Nat'l Cemetery</b> 23d. LOCATION (City or Town) <b>Arlington</b> (County) <b>Virginia</b> (State)	
24. FUNERAL DIRECTOR <b>Glen Carter Cullenarts 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.</b>		25a. RECD' BY REGISTRAR <b>APR 23 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

31820

PIGGS

WINDSOR HORN

ENGLISH

WINDSOR HORN

CLIMATE: SEVERE

CLIMATE: SEVERE

IN THE COUNTRY: 20%

IN THE COUNTRY: 20%

WINTER: 12°

WINTER: 12°

WINTER:

SPRING: 30%

XX

SPRING:

SUMMER: 15% WINTER: 15% - 20%

(S) (S) (S) (S)

(S) (S) (S) (S)

WINTER: 20% SPRING: 20% SUMMER: 20% AUTUMN: 20%

WINTER: 20% SPRING: 20% SUMMER: 20% AUTUMN: 20%

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05313

## CERTIFICATE OF DEATH

05317

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>11 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethesda-Silver Spring Nursing Home</b>			d. STREET ADDRESS <b>10225 Kensington Pkwy.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ANGELA</b>		First <b>DAVIS</b>	Middle <b>DASSORI</b>	Lost	4. DATE OF DEATH <b>April 1 1967</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 16, 1877</b>	9. AGE (In years last birthday) <b>89 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maine</b>	
13. FATHER'S NAME <b>JOHN JACKSON DAVIS</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET TWOMEY</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Frederic Dassori, 3000 Conn. Ave., DC</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> 4200 DUE TO (b) <b>Congestive Heart Failure</b> many months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Atherosclerotic Heart Disease</b> many years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pneumonia, bilateral arterial thrombosis(?) lowest</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg, etc.)	20f. (City or town) <b>Brooklyn</b>	(County) (State) <b>New York</b>
21. I certify that (I) ( <b>this hospital</b> ) attended the deceased from <b>1964 - 1967</b> to <b>April 1, 1967</b> , that (I) ( <b>not</b> ) last saw the deceased alive on <b>March 30, 1967</b> , and that death occurred at <b>10 PM</b> from causes and on the date stated above.					
22a. SIGNATURE <b>George H. Mitchell</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>April 2, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>GEORGE H. MITCHELL</b>		22d. ADDRESS <b>11125 Rockville Pike, Rockville, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Greenwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Brooklyn, New York</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		ADDRESS <b>BETHESDA, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>APR 7 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

SICCO

SICCO



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05320

## CERTIFICATE OF DEATH

05318

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Kentucky</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>177 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington</b>		d. STREET ADDRESS <b>304 South Hanover Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John</b>		First <b>Malcolm</b>	Middle <b>DAVIS</b>
4. DATE OF DEATH <b>April 13 1967</b>	Month <b>April</b>	Day <b>13</b>	Year <b>1967</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Aug. 30, 1906</b>	9. AGE (In years last birthday) <b>60 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USMC - Retired</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>-- --</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Morganfield, Kentucky</b>	
13. FATHER'S NAME <b>Thompson Bennett Davis</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Clements</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>1930-1960</b>		16. SOCIAL SECURITY NO. <b>- - -</b>	
17. INFORMANT C-9, Frankfort		Address <b>Kentucky</b>	
		<b>Mrs. Alice M. Davis, 333 East 4th St., APT</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-intestinal hemorrhage</b>			
DUE TO <b>1810</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Duodenal ulcer, chronic intestinal obstruction</b>			
DUE TO			
(c) <b>Carcinoma of the bladder with carcinomatosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Approx. 3 weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>
20f. (City or town) <b>---</b>		(County) <b>---</b> (State) <b>---</b>	
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>Oct. 18, 1966</b> , to <b>April 13, 1967</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>April 13, 1967</b> , and that death occurred at <b>1212 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>James L. Snyder, M.D.</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <b>James L. Snyder, M.D.</b>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>James L. Snyder, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-14-1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>
23d. LOCATION (City or Town) <b>Arlington</b>		(County) <b>Virginia</b> (State) <b>Virginia</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Son</b> <b>5130 Wisconsin Ave., N.W., Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>DATA APR 20 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.  
5 may be retained for your files.

05321

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05319

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		b. COUNTY <del>Germantown</del> Montgomery	
c. LENGTH OF STAY IN lb <b>1hr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>Rt #2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Joseph Hayes Davis</b>		First	Middle
4. DATE OF DEATH <b>4</b>		Month	Day Year
5. SEX <b>Male</b>		Lost	7 1967
6. COLOR OR RACE <b>White</b>		8. DATE OF BIRTH <b>1/30/23</b>	9. AGE (In years lost birthday) <b>44 000 yrs.</b>
7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. KIND OF BUSINESS OR INDUSTRY <b>Painter</b>	11. BIRTHPLACE (State or foreign country) <b>Reedville, Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Noble Davis</b>	
14. MOTHER'S MAIDEN NAME <b>Ethel M. Marsh</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>NO</b>	
16. SOCIAL SECURITY NO. <b>579-16-7046</b>		17. INFORMANT Address <b>Wife Christine Rt #2 Germantown Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>816.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Multiple extreme injuries incurred in head-on auto-auto collision	
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased, driver, collided head-on with auto which crossed median strip on Rte. 495</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>6:55 AM 4-7 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>
20f. (City or town) <b>Silver Spring Montg. Md.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>April 7, 1967</b>	
ACTUAL SIGNATURE <b>Belden R. Reap</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL/CREMATION <del>REBURNED</del>		23b. DATE THEREOF <b>April 10, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Roseland</b>		23d. LOCATION (City or Town) <b>Reedville, Virginia</b>	
24. FUNERAL DIRECTOR <b>Glen Carter</b>		ADDRESS <b>8434-Ga. Ave</b>	
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc. Silver Spring, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>APR 11 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #lc Film #G388 W26/67 pg

05322

## CERTIFICATE OF DEATH

05320

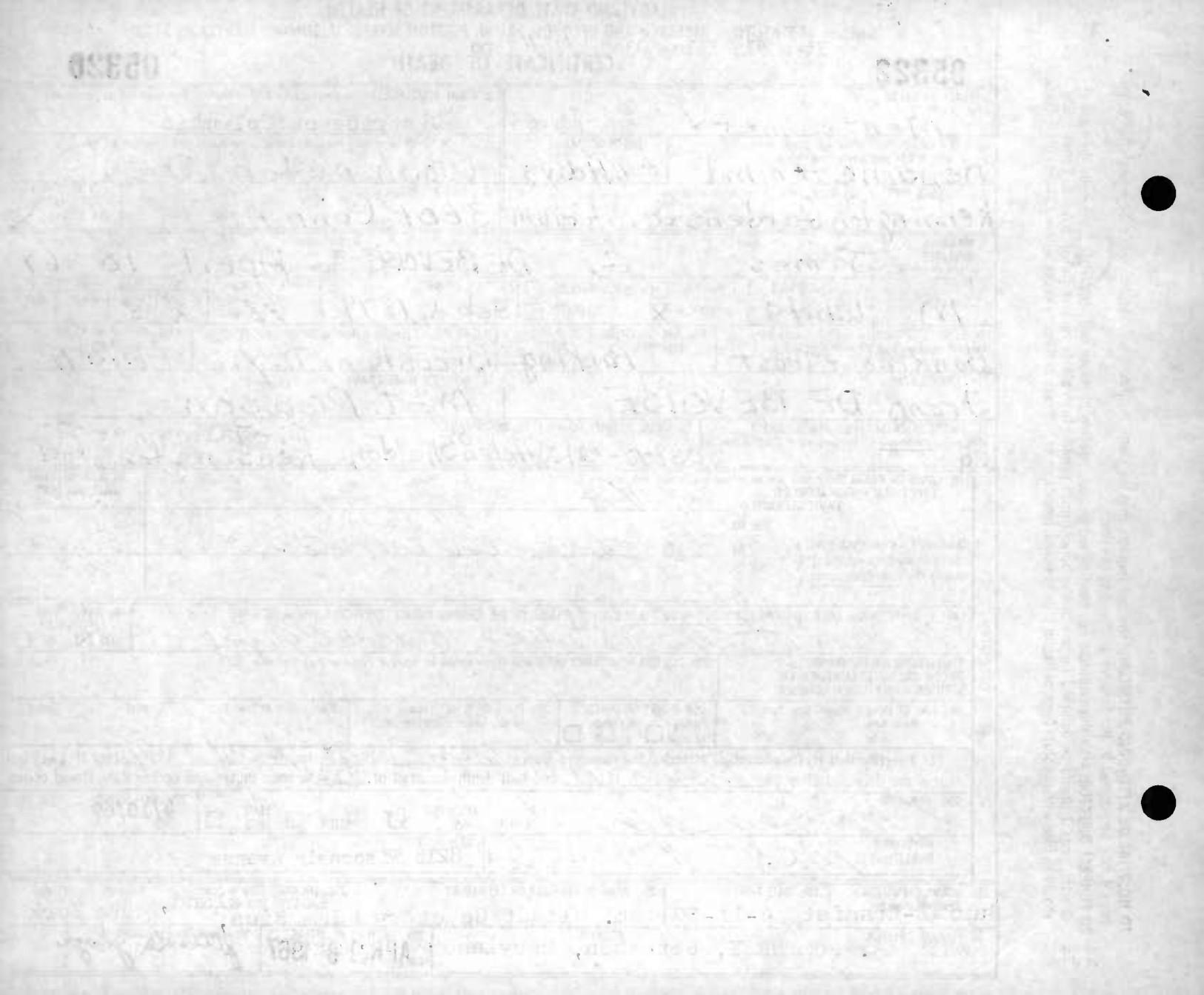
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington, md</b>		c. LENGTH OF STAY IN 16 <b>93 69 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kensington Gardens Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>James</b>	Middle <b>G.</b>	Last <b>DE BEVOISE</b>
S. SEX <b>m</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>Feb 2, 1879</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Banking &amp; Trust</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Brooklyn, N.Y.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Frank DE BEVOISE</b>	14. MOTHER'S MAIDEN NAME <b>Mgt. Pawson.</b>	9. AGE (In years lost birthday) <b>88 yrs.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>068-10-7212</b>	17. INFORMANT <b>Helen Sheldon</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>33IX</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cerebral Atherosclerosis</b> DUE TO (b) (c)
			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Undernutrition due to difficulty swallowing</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1967</b> to <b>April 1967</b> , that (I) (we) last saw the deceased alive on <b>April 1967</b> , and that death occurred at <b>12:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Marvin Wadler</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4/10/67</b>
22c. PHYSICIAN'S NAME (Type) <b>MARVIN WADLER</b>	22d. ADDRESS <b>8218 Wisconsin Avenue</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-11-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Long Island, Jamaica, New York</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>	ADDRESS <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>	25a. REC'D BY REGISTRAR DATE <b>APR 13 1967</b>	25b. REGISTRAR'S SIGNATURE <b>James George</b>

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05323

CERTIFICATE OF DEATH

05321

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> MONTG.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN lb <b>10 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>16 Maryland Ave</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>Elsie Willard Demory</b>		First	Middle	Lost	4. DATE OF DEATH	Month	Doy Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 11th 1888</b>	9. AGE (If years lost birthday) <b>79 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Dows <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>III</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Lovettsville, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles W. Spring</b>		14. MOTHER'S MAIDEN NAME <b>Laura J. Spring</b>		17. INFORMANT Address <b>William L. Demory. Gaithersburg. Md.</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>17. INFORMANT</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Coronary occlusion</b> INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) <b>Hypertension cardiovascular disease.</b> 5 years DUE TO (c) <b>Certificate signed after consultation with Dr. Ball, medical examiner</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>No</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Rockville</b>	(County) <b>Md.</b>	(State) <b>MD</b>
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19, to <b>April 2, 1967</b> (I) (we) last saw the deceased alive on <b>8/21</b> , 1966, and that death occurred at <b>10 P.M.</b> from causes and on the date stated above.								
22a. SIGNATURE <b>W.L. Linticum</b>		M.D. <input type="checkbox"/> ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4/23/67</b>				
22c. PHYSICIAN'S NAME (Type) <b>W.L. Linticum, M.D.</b>		22d. ADDRESS <b>110 S. Rock St. Rockville, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-26-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Lovettsville Union</b>		23d. LOCATION (City or Town) <b>Lovettsville</b> (County) <b>Md.</b> (State) <b>VA</b>		
24. FUNERAL DIRECTOR <b>Ernest C. Gartner.</b>		ADDRESS <b>Gaithersburg, Md.</b>		25a. REC'D. BY REGISTRAR <b>APR 26 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05324

CERTIFICATE OF DEATH

05322

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank Carl Lewis</b>		First <b>Frank</b>	Middle <b>Carl Lewis</b>
3. NAME OF DECEASED (Type or print) <b>Frank Carl Lewis</b>		Last <b>DETTMANN</b>	4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1967</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY - - -	
13. FATHER'S NAME <b>Frank Dettmann</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Cliff</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war & dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>579 44 4133</b>	
17. INFORMANT N.W., Washington Address <b>Mrs. Katherine Dettmann, 3725 Upton St.,</b>		D. C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LUNG</b> 103X DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause _____ last. (c) _____			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>Mar. 29</b> , 19 <b>67</b> to <b>Apr. 16</b> , 19 <b>67</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>Apr. 16</b> , 19 <b>67</b> , and that death occurred at <b>2:00</b> P.M. from causes and on the date stated above.		22b. DATE SIGNED <b>P.M. Apr. 17, 1967</b>	
22a. SIGNATURE <i>John B. Emery</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>Apr. 17, 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>John B. Emery, Jr., M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-19-1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>
24. FUNERAL DIRECTOR <b>Jos. Gawler &amp; Sons</b>		ADDRESS <b>5130 Wisconsin Ave. N.W., Washington, D.C.</b>	25a. REC'D BY REGISTRAR <b>APR 20 1967</b>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05325

## CERTIFICATE OF DEATH

05323

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>9 day</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>1001 E. Mont. Ave.</i>	
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>DEVLIN</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1967</b>	
S. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/26/1894</b> 9. AGE (In years lost birthday) <b>73</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Penna</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Brady</i>		14. MOTHER'S MAIDEN NAME <i>Catherine M'Connell</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Daughter Mrs. Lulu Scenell</i>		Address <i>Penna as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b> INTERVAL BETWEEN ONSET AND DEATH <b>332X</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Thrombosis Left Internal Carotid Artery</b> 8 days			
DUE TO (b) <b>Generalized Atherosclerosis</b> undetermined			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>None</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) <b>Hanover</b> (County) <b>Penna</b> (State) <b>MD</b>
21. I certify that (I) (this hospital) attended the deceased from <b>JAN 15</b> , 19 <b>66</b> , to <b>17 April</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>16 April</b> , 19 <b>67</b> , and that death occurred at <b>7:35 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Stanley M. Bialek</i>		22b. DATE SIGNED <b>17 April 67</b>	
22c. PHYSICIAN'S NAME (Type) <i>Stanley M. Bialek, M. D.</i>		22d. ADDRESS <i>8218 Wisconsin Ave., Bethesda, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <b>4-20-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Mary's Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <b>Hanover, Penna.</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS 25a. REC'D BY REGISTRAR <b>APR 24 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

CSE30

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05326

CERTIFICATE OF DEATH

05324

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE	
Montgomery Maryland		Washington, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.		c. LENGTH OF STAY IN lb 14 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		d. STREET ADDRESS 3636 16th St. N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2015 East-West Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
e. NAME OF DECEASED (Type or print) Mary Wakefield Dickson		f. DATE OF DEATH APRIL 22 1967	
f. SEX F 6. COLOR OR RACE WHITE		g. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
h. 10a. USUAL OCCUPATION (Give kind of work done Ret.)		i. 10b. KIND OF BUSINESS OR INDUSTRY Teacher	
j. 13. FATHER'S NAME John Gardiner		k. 11. BIRTHPLACE (County & State, or foreign country) OHIO	
l. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No None		m. 16. SOCIAL SECURITY NO. Yes	
n. 17. INFORMANT Robert W. Dickson		o. 2211 Wash Avenue Address Silver Spring, Md.	
p. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 163X DUE TO Pulmonary Carcinoma		q. INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) DUE TO			
		(c)	
r. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Colon pneumonia + Diabetes			
s. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		t. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
u. 20c. TIME OF INJURY (Month Year Hour to m. 24 hrs. 22 Apr. 1967)		v. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
w. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		x. 20f. (City or town) (County) (State)	
y. 21. I certify that (I) (this hospital) attended the deceased from Jan 1965, to 22 Apr. 1967, that (I) (we) last saw the deceased alive on 4-21 1967, and that death occurred at 2:40 AM, from causes and on the date stated above.		z. 22b. DATE SIGNED 4-22-67	
aa. 22c. PHYSICIAN'S NAME (Type) S. J. RANDALL, MD		bb. ADDRESS 3001 Georgia Ter. N.W.	
cc. 23a. BURIAL, CREMATION, REMOVAL (Specify) Trans-cremation		dd. 23b. DATE THEREOF Apr 24, 1967	
ee. 23c. NAME OF CEMETERY OR CREMATORIAL Green Lawn Cemetery		ff. 23d. LOCATION (City or Town) (County) (State) Columbus, Ohio	
gg. 24. FUNERAL DIRECTOR C. Glen Carter, Warner E. Pumphrey, Inc.		hh. 25a. ADDRESS 8434 Georgia Avenue	
ii. 25b. REG'D BY REGISTRAR APR 27 1967		jj. 25b. REGISTRAR'S SIGNATURE Charles Judge	

02354

1977 RELEASE UNDER E.O. 14176 - THIS IMAGE MAY BE UNRELIABLE

02354

TOP SECRET

**1** 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05325

05327		CERTIFICATE OF DEATH										05325													
1. PLACE OF DEATH a. COUNTY <i>Maryland</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>					b. COUNTY <i>Montgomery</i>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>					c. LENGTH OF STAY IN lb <i>1b</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross</i>					d. STREET ADDRESS <i>615A Silver Spring Ave</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
168 3. NAME OF DECEASED (Type or print) <i>Ann</i>					First <i>D</i>	Middle <i>Ditman</i>	Last <i>4</i>	4. DATE OF DEATH Month <i>4</i>	Month <i>4</i>	Day <i>23</i>	Year <i>1967</i>														
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/5/36</i>	9. AGE (In years last birthday) <i>30 yrs.</i>	10. US OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School Teacher</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Mass</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		IF UNDER 1 YEAR Months <i>0</i>		IF UNDER 24 HRS. Days <i>0</i>		Hours <i>0</i>	Min. <i>0</i>							
13. FATHER'S NAME <i>Walter C. Bullock</i>		14. MOTHER'S MAIDEN NAME <i>Elise Avery</i>																							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <input type="checkbox"/> No (If yes give NO dates of service)		16. SOCIAL SECURITY NO. <i>006-34-7784</i>		17. INFORMANT <i>William F. Ditman</i>		Address <i>Same as #2</i>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1909</i>		DUE TO <i>Melanoma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Adenocarcinoma of Breast</i>		(b) <i></i>																							
DUE TO <i></i>		(c) <i></i>																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i></i>																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>																							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) <i></i>		(State) <i></i>															
21. I certify that (I) (this hospital) attended the deceased from <i>Jersey, 1966, to 4/23, 1967</i> , that (I) (we) last saw the deceased alive on <i>4/23 1967</i> , and that death occurred at <i>TOP M</i> , from causes and on the date stated above.																									
22a. SIGNATURE <i>G. Lennard Gold</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4/24/67</i>															
22c. PHYSICIAN'S NAME (Type) <i>G. Lennard Gold, M.D.</i>		22d. ADDRESS <i>8641 Colesville Rd., Silver Spring, Md.</i>																							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>4/25/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park Cemetery</i>		23d. LOCATION (City or Town) <i>Baltimore</i>		(County) <i>Maryland</i>		(State) <i></i>															
24. FUNERAL DIRECTOR <i>J.T. Stansbury</i>		ADDRESS <i>6411 Windsor Mill Rd.</i>		25a. REC'D BY REGISTRAR <i>APR 26 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																			
VR A15 (4) 20 M 1/66																									

65620

HIGH 30 - STAPLES

65630

65	100% misprint	not stapled
62	42/51	stapled
A25	no off	not stapled

65620	100% misprint	not stapled
65630	42/51	stapled

Items 18&21 Film 390 6-22-MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

05328

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05326

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>555 Thayer Avenue</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Peter L. Doerflein</b>		First	Middle	Lost	4. DATE OF DEATH <b>April 26</b>	Month	Doy	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1896</b>	9. AGE (In years lost birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electronic Company</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Louis Doerflein</b>				14. MOTHER'S MAIDEN NAME <b>(unknown)</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>081-28-8220</b>		17. INFORMANT <b>Ruth Doerflein</b>		Address <b>555 Thayer Avenue Silver Spring, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatty metamorphosis of liver with</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { lost. (b) <b>Cerebral fat embolism</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						22. DATE SIGNED <b>4/26/1967</b>		
ACTUAL SIGNATURE <b>Belden</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>BELDEN R. REAR M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Apr 26, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Crematory</b>		23d. LOCATION (City or town) <b>Prince Georges Co., Md.</b>		(County) (State)
24. FUNERAL DIRECTOR <b>Glen Carter</b>		ADDRESS <b>Warren E. Humphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>APR 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
VR A15ME (5) 6M 1/66								



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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05329		CERTIFICATE OF DEATH		05327	
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>28 1/2 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSPITAL</b>		d. STREET ADDRESS <b>12325 NEWHAMPSHIRE AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. DATE Month <b>4</b> / Day <b>1</b> Year <b>1967</b>					
3. NAME OF DECEASED (Type or print) <b>PAULINE BARBARA DONDERO</b>		First	Middle	Lost	4. DATE OF DEATH
5. SEX <b>FE</b>		6. COLOR OR RACE <b>WHT</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>9/24/85</b>		9. AGE (In years lost birthday) <b>81 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>LOUIS LEHMANN</b>		14. MOTHER'S MAIDEN NAME <b>MARY STEPPER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Raphael Dondero</b> Address <b>5602 42nd Ave. S., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>{</b>		DUE TO (b) <b>Congrene - rt lower leg</b>		<b>3 days</b>	
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Generalized arteriosclerosis</b>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 15</b> , 19 <b>66</b> , to <b>Apr 13</b> , 19 <b>67</b> , that (I) (was) last saw the deceased alive on <b>Apr 13</b> , 19 <b>67</b> , and that death occurred at <b>7008 M.</b> , fram causes and on the date stated above.					
22a. SIGNATURE <b>R. H. Sandstrom</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 3, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. H. Sandstrom M.D.</b>		22d. ADDRESS <b>7701 Carroll Ave Takoma Park, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 6, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Fort Lincoln Cemetery 8434 Georgia Avenue</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas, Inc. Warner E. Pumphrey, Inc.</b>				25a. APRD. BY REGISTRAR DATE <b>APR 7 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

FSC30

Trade to 5000m²

CS520

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05330

CERTIFICATE OF DEATH

05328

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>22 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NAVAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John</b>		First <b>Albert</b>	Middle <b>Donehoo</b>
4. DATE OF DEATH <b>April 7 1967</b>		Month	Doy Year
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>31 DEC 02</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. NAVY Lt. Comdr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (County & State, or foreign country) <b>ATLANTA, GEORGIA</b>
13. FATHER'S NAME <b>JOHN ALBERT DONEHOO</b>		14. MOTHER'S MAIDEN NAME <b>ALICE UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>578-50-2909 A X3T0612XXXX</b>	17. INFORMANT <b>MRS. IRENE A. DONEHOO</b>
			Address <b>#2</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <b>22 DAS</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5810</b>		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>lost.</b>		(b) _____	
		DUE TO	
		(c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>17 MARCH, 1967</b>		(County) <b>ARLINGTON</b>	(State) <b>VA</b>
21. I certify that (I) (this hospital) attended the deceased from <b>17 MARCH, 1967</b> , to <b>7 APRIL, 1967</b> , that (I) (we) last saw the deceased alive on <b>7 APRIL, 1967</b> , and that death occurred at <b>5:10PM</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>9 April 67</b>	
22a. SIGNATURE 		M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. ADDRESS
22c. PHYSICIAN'S NAME (Type) <b>DAVID R. FOREMAN LT, MC, USN</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
		23b. DATE THEREOF <b>Apr. 12-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>ARLINGTON NATIONAL</b>
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>		25a. ADDRESS <b>1661 GOOD HOPE ROAD, SE, WDC</b>	25b. REC'D BY REGISTRAR <b>APR 11 1967</b>
			25b. REGISTRAR'S SIGNATURE 

02388

RECEIVED IN LIBRARY

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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05331

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05329

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>214</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		e. STREET ADDRESS <i>13020 Turkey Branch Parkway</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John Dotsey</i>	First <i>J.</i>	Middle <i>Dotsey</i>	Last <i>J. Dotsey</i>
4. DATE OF DEATH <i>June 8, 1967</i>	Month <i>June</i>	Doy <i>18</i>	Year <i>1967</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 8, 1913</i>
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) <i>53 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i> Doy <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Hospital Cashier accounting supervisor</i>		11. BIRTHPLACE (State or foreign country) <i>Georgetown Pennsylvania USA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>William Dotsey</i>		14. MOTHER'S MARRIED NAME <i>Ann (Kohnecker)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> <i>1944 - 1961</i>		16. SOCIAL SECURITY NO. <i>131-09-2897</i>	
17. INFORMANT <i>Mrs John Dotsey - Absent</i>		18. ADDRESS <i>13020 Turkey Branch Parkway Rockville, Md</i>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Insufficiency Acute</i> DUE TO (c) <i>Cardio Vascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> years.	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>(County)</i> <i>(State)</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John G. Ball</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23o. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr 31, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIALy <i>Arlington National Cemetery</i>		23d. LOCATION (City or Town) <i>(County)</i> <i>(State)</i> <i>Arlington, Virginia</i>	
24. FUNERAL DIRECTOR <i>Glen Carter</i> ADDRESS <i>18434 Georgia Avenue</i>		25o. REC'D BY REGISTRAR <i>APR 24 1967</i>	
Warner E. Pumphrey, Inc. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

88630

88630

- ✓ small shrubs  
✓ yellowish green flowers  
✓ light green leaves  
✓ off white flowers  
✓ irregular flowers  
✓ small shrubs  
✓ small - pink flowers  
✓ small shrubs  
✓ small shrubs

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05332

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05330

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Germantown</i>		c. LENGTH OF STAY IN lb <i>Life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>112 Berryville Rd.</i>		d. STREET ADDRESS <i>112 Berryville Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Charles E. Drivers</i>		First <i>C</i>	Middle <i>E.</i>
4. DATE OF DEATH <i>April 23 1967</i>		Month <i>Apr.</i>	Day <i>23</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH <i>Nov. 6, 1946</i>		9. AGE (In years lost birthday) <i>21</i>	10. IF UNDER 1 YEAR Months <i>2</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Walter Driver</i>	
14. MOTHER'S MAIDEN NAME <i>Melouise Jackson</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemopericardium. Massive. CT embolade.</i> INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>451X</i>		DUE TO (b) <i>Rupture. Thoracic Aorta, Spontaneous</i>	Scattered
		DUE TO (c) <i>Cystic Media Necrosis of Aorta, Idiopathic</i>	Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20a. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
20. (19)		20d. (19)	20e. (Baltimore) (Baltimore) (Md.)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John J. Rogers, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John J. Rogers, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county) <i>1919 Lombard St. S.E. Washington, D.C. 20502</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr. 28, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Seneca Com. Cemetery</i>
23d. LOCATION (City or Town) <i>Seneca Montg. Md.</i>		(County) <i>Montgomery</i>	(State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>Robert L. Swanson Rockville, Md.</i>		ADDRESS	25a. REC'D BY REGISTRAR <i>APR 27 1967</i>
			25b. REGISTRAR'S SIGNATURE <i>Oscar L. Judge</i>

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33333

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4** may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05333

## CERTIFICATE OF DEATH

05331

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4743 Bradley Blvd.			d. STREET ADDRESS 4743 Bradley Blvd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED First ADRIAN O. MIDDLE DURHAM, Last Sr.			4. DATE OF DEATH Month April Day 13, Year 1967					
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH July 6, 1890	9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Air Engineer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Fairfax County, Va.			12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frank Durham			14. MOTHER'S MAIDEN NAME Molly Scott					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I-Navy		16. SOCIAL SECURITY NO. 579-60-7204		17. INFORMANT Wife Margaret H. Durham Address Same as Item 2.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cerebral Hemorrhage (Stroke)			INTERVAL BETWEEN ONSET AND DEATH 2 hours		
331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c)			Cerebral Arteriosclerosis			10 years		
DUE TO (b) DUE TO (c)			Generalized Arteriosclerosis			20 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (This hospital) attended the deceased from <u>Mar 24</u> , 19 <u>67</u> , to <u>April 13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 5</u> , 19 <u>67</u> , and that death occurred at <u>2 pm</u> M, from causes and on the date stated above.						22b. DATE SIGNED <u>April 13, 1967</u>		
22a. SIGNATURE <u>Stephen Hulbert</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. ADDRESS 3000 Dent Place N. W. Washington, D. C.		
22c. PHYSICIAN'S NAME (Type) R. STEPHEN HULBERT			22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-17-67		23c. NAME OF CEMETERY OR CREMATORIAL Natl. Mem. Park Cem.		23d. LOCATION (City or Town) (County) (State) Falls Church, Virginia		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland			ADDRESS			25a. REC'D BY REGISTRAR APR 17 1967		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05334

## CERTIFICATE OF DEATH

05332

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Montgomery Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Silver Spring		2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Holy Cross Hospital		f. STREET ADDRESS	
First MIDDLE Last		Month Day Year	
3. NAME OF DECEASED (Type or print) JANICE R. DYSON		4. DATE OF DEATH 4 12 1967	
5. SEX F 6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
minor		-	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
13. FATHER'S NAME Richard Dyson		14. MOTHER'S MAIDEN NAME Pamela Gaunt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
no		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic malignancy 180X DUE TO (b) Wilma Turner Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 2+ yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERTHLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-10-1967 to 4-12-1967, that (I) (we) last saw the deceased alive on 4-12-1967, and that death occurred at 12:55 P.M. from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED 4-13-67	
22c. PHYSICIAN'S NAME (Type) ALLAN B. COLEMAN, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS 1605 N. PORTAGE DR. NW, WASH. DC 20012	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/15/67	
23c. NAME OF CEMETERY OR CREMATORIUM GATES OF HEAVEN		23d. LOCATION (City, town or county) (State) SILVER SPRING, MONTG., MD.	
24. FUNERAL DIRECTOR George R. Donnelly		25a. REC'D BY REGISTRAR APR 13 1967	
ADDRESS Rockville Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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SEEDS

Brand new

Delivery service

Delivery

Delivery

Delivery

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

<b>05335</b>		<b>CERTIFICATE OF DEATH</b>					<b>05333</b>		
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb					<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5415 Burling Road</b>					d. STREET ADDRESS <b>5415 Burling Road</b>				
<b>3. NAME OF DECEASED</b> First <b>EDWARD</b> Middle <b>F.</b> (Type or print)		<b>4. DATE OF DEATH</b> <b>Dziura</b>		<b>Month</b> <b>4</b>	<b>Year</b> <b>1967</b>	<b>Doy</b> <b>3</b>			
<b>S. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>10-1-1900</b>		<b>9. AGE (In years last birthday)</b> <b>66 yrs.</b>	
<b>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Executive Chief-Retired-Shoreham Hotel</b>		<b>11. KIND OF BUSINESS OR INDUSTRY</b> <b>Germany</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					
<b>13. FATHER'S NAME</b> <b>Joseph Dziura</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Florentine Klyck</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</b> - - - - -		<b>16. SOCIAL SECURITY NO.</b> <b>578-07-6463</b>		<b>17. INFORMANT</b> <b>Helen Bell, See Item #2.</b>		<b>Address</b>			
<b>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</b> <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>CONGESTIVE HEART FAILURE</b> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH</span> <b>420.1</b> <span style="float: right;">1 year</span> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) and (c).</b>		<b>DUE TO</b> <b>(b)</b> <b>HYPERTENSION, CORONAR</b> <span style="float: right;">10-15 yrs.</span> <b>DUE TO</b> <b>(c)</b> <b>ARTERIOSCLEROSIS, DIABETES</b> " "							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>GALL STONES</b>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. MEDICAL CERTIFICATION</b> <b>ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b> <b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. <b>19</b> <b>20d. INJURY OCCURRED</b> p.m. <b>19</b> <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input type="checkbox"/> <b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b> <b>20f. (City or town) (County) (State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1945</b> , 19 <b>to date</b> , 19 <b>,</b> that (I) (we) last saw the deceased alive on <b>4/3</b> , 19 <b>67</b> , and that death occurred at <b>11:15</b> M, from causes and on the date stated above.									
<b>22a. SIGNATURE</b> <b>Paul R Wilner</b>				<b>22b. DATE SIGNED</b> <b>1967</b>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>PAUL R WILNER</b>		<b>22d. ADDRESS</b> <b>2500 CALVERT ST. N.W.</b>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4-6-1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <b>Fort Lincoln Cemetery</b>		<b>23d. LOCATION (City or Town) (County) (State)</b> <b>Prince Georges Co. Md.</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Joseph Gavler's Sons, Inc.</b>		<b>ADDRESS</b> <b>5130 Wisconsin Ave. N.W. Wash. D.C.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>APR 10 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Almonia Judge</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items #4 & 21 Film #G387 4/20/67 PC

05336

CERTIFICATE OF DEATH

05334

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> MONTGOMERY ✓ b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>6 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		d. STREET ADDRESS <b>3900 CALVERTON DRIVE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NAVAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EDWIN SHELL EARNHARDT</b>		First	Middle	Lost	4. DATE OF DEATH <b>APRIL 14 1967</b>	Month	Doy Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH <b>JUN. 10, 1895</b>	9. AGE (In years lost birthday) <b>71 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Captain US NAVY</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (Country & State, or foreign country) <b>LENOIR, N. CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>UNKNOWN Earnhardt</b>				14. MOTHER'S MAIDEN NAME <b>BLANCHE UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I &amp; 2</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>GLADYS R. EARNHARDT</b>		
Address <b>3900 CALVERTON DRIVE HYATTSVILLE, MARYLAND</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Coronary Atherosclerotic Cardiovascular Disease</b> 4801 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ stating the underlying cause (c) _____ DUE TO last _____ DUE TO last _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>APR 9, 1967</b> , to <b>APR 15, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>APR 24, 1967</b> , and that death occurred on <b>23251</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>R. H. Spaur</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>16 April 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>W. H. SPAUR, LCDR MC USN</b>				22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>138 v. 1</b>		23b. DATE THEREOF <b>4-18-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>ARLINGTON NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON VA.</b>	
24. FUNERAL DIRECTOR <b>FRANCIS GASCH'S SONS, HYATTSVILLE, MD.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>APR 18, 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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Items 18-21 Film 390 6-23 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

05337

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05335

Dr.  
Fisher  
  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		b. COUNTY <i>Seat Pleasant</i>	
c. LENGTH OF STAY IN 1b <i>D.O.A.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>5264 Marbough Pike</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San + Hospt.</i>		d. STREET ADDRESS <i>1601</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Dominic Thomas Emilio</i>		4. DATE OF DEATH <i>4 27 1967</i>	
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>7-16-38</i>
8. AGE (In years last birthday) <i>28</i>		9. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steel Worker</i>		11. BIRTHPLACE (State or foreign country) <i>D.C.</i>	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Salvatore D. Emilio</i>		14. MOTHER'S MAIDEN NAME <i>Mary Hessler</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>157-28-6486</i>	
17. INFORMANT <i>Mary J. Emilio - 3966 - PA Ave SE</i>		Address <i>W 14th St. DC</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>821.4</i>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO femur, left ilium, left arm and ribs (c) DUE TO with exsanguination			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>Deceased found dead beside wrecked motorcycle on Riggs Road</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>xx</i> p.m. <i>4-27 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Street</i>
20f. (City or town) <i>Hyattsville</i> (County) <i>PrGeo</i> (State) <i>Md.</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <i>Accident</i> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Deap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <i>BELDEN R. DEAP, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 2-1967</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Alexandria Nat'l. Cemetery</i>
23d. LOCATION (City or town) <i>Alexandria</i> (County) <i>Virginia</i> (State)			
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>		ADDRESS <i>1601 Good Hope Rd SE Wash DC</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>
		25b. REGISTRAR'S SIGNATURE	
		DATE <i>MAY 1 1967</i>	

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STATE OF CALIFORNIA & SAVING BANK

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05338

CERTIFICATE OF DEATH

05336

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>7 months</i>	
c. LENGTH OF STAY IN 1b <i>7 months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Montgomery Conv. &amp; Nursing Home</i>		d. STREET ADDRESS <i>151</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Charlotte E. G. Farquhar</i>		First <i>Charlotte</i>	Middle <i>E. G.</i>
Last <i>Farquhar</i>		4. DATE OF DEATH <i>4-29 1967</i>	Month Day Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Griffith</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Singleton</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-48-3814</i>	
17. INFORMANT <i>Mrs. Catherine Willcox</i>		Address <i>Gaithersburg, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <i>Pulmonary edema, acute</i> DUE TO <i>4221</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>status sacerote cardiovascular disease</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>11-9 1966</i> to <i>4-29 1967</i> , that (I) (we) last saw the deceased alive on <i>4-28 1967</i> , and that death occurred at <i>9526</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>A.D. Bonifant</i>		22b. DATE SIGNED <i>5/1/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>A.D. Bonifant, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS <i>Medical Center, Sandy Spring, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5-2-67</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>St. Johns</i>
24. FUNERAL DIRECTOR <i>Francis H. Barber Laytonsville, Md.</i>		ADDRESS	23d. LOCATION (City, town or county) (State) <i>Olney, Md.</i>
		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	23d. REGISTRAR'S SIGNATURE
		DATE <i>MAY 3 1967</i>	

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Information

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Year

2011

Mr. Christopher M. Cook, Superintendent

Year

and # 10-3-2-1512

of employment record

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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05339		CERTIFICATE OF DEATH		05337	
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Carroll Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>5½ hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FINCHAM</b> , <b>BABY BOY</b>		First <b>FINCHAM</b> Middle <b>BABY</b> Last <b>BOY</b>	4. DATE OF DEATH <b>4</b> Month <b>16</b> Doy <b>1967</b> Year		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-16-67</b>		9. AGE (In years lost birthday) yrs. <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Carroll</b> <b>Montgomery, Md.</b>	
13. FATHER'S NAME <b>Perry Hankins</b>		14. MOTHER'S MAIDEN NAME <b>Mary Fincham</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Hospital Records</b> Address <b>Olney, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>poliomyelitis</b> <b>7760X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1005 M</b>	
20f. (City or town) <b>Howard Co.</b> (County) <b>Md.</b> (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>April 16, 1967</b> to <b>April 16, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 16, 1967</b> , and that death occurred at <b>1005 M</b> , from causes and on the date stated above.					
22a. SIGNATURE <i>Chester Leroy Wagstaff</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-17-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Chester Wagstaff</b>		22d. ADDRESS <b>Sandy Spring Med. Center, Sandy Sp.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-18-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>HARMONY Cemetery</b>	
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>		ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 21 1967</b> DATE	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05340

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05338

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Great Falls</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>New Jersey</i> b. COUNTY	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Penns Grove</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Parking Lot</i>		d. STREET ADDRESS <i>337 N. Broad St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Ian Edward Finlayson</i>		First <i>Ian</i>	Middle <i>Edward</i>
4. DATE OF DEATH <i>APRIL 26 1967</i>		Month <i>APRIL</i>	Doy Year <i>26 1967</i>
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED WIDOWED <input type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/>
8. DATE OF BIRTH <i>Aug 8, 1940</i>		9. AGE (In years last birthday) <i>26 yrs.</i>	
10. USUAL OCCUPATION (Give kind of work done during most full time even if retired) <i>U. S. NAVY</i>		11. BIRTHPLACE (State or foreign country) <i>CAMBRIDGE, MASS.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>DONALD J. FINLAYSON (DEC'D)</i>		14. MOTHER'S MAIDEN NAME <i>ELEANOR PETERSON</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <i>068 32 5070</i>	
17. INFORMANT <i>NAVY RECORDS USNH BETHESDA, MARYLAND</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shot Gun blast of Head Self inflicted</i> DUE TO <i>Sudden</i> 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c) lost.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Muzzle of shotgun in mouth + pulled trigger blowing off Head</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>4/26 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Parking Lot</i>
20f. (City or town) <i>Great Falls Mont. Md.</i>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John G. Ball</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <i>W.W. Chambers Co 1400 Chapin St</i>			
22. DATE SIGNED <i>4/26/67</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE THEREOF <i>4-29-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>F. Lincoln</i>
24. FUNERAL DIRECTOR <i>W.W. Chambers Co</i>		ADDRESS <i>1400 Chapin St</i>	23d. LOCATION (City or Town) (County) (State) <i>Dr. Geo. G. MD</i>
25a. REC'D BY REGISTRAR <i>MAY 1 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

86620

1967-70 ANNUAL TRENDS IN

G3801

present

Chlorophyll

annual mean

Wet years

10 years WET

dry years

35 years - median length 0.4

32 years P-A M M

30 years

10 years DRY (1967) 1968-69 1969-70

1968-69 1969-70 1970-71 1971-72

1967-68 1968-69 1969-70 1970-71

1968-69 1969-70 1970-71 1971-72

1968-69 1969-70 1970-71 1971-72

1968-69

1969-70

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05339

CERTIFICATE OF DEATH

05339

1. PLACE OF DEATH e. COUNTY		Items #2c & d Film #05339 4/1967		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)	
Montgomery MARYLAND				a. STATE Md.	b. COUNTY Montg.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burtonsville		c. LENGTH OF STAY IN lb 14.36 Month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lippard's Home for Senior Citizens		d. STREET ADDRESS 1208 Noyes Dr 87018 Greenbelt Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Stella	Last Fleisher	4. DATE OF DEATH Apr 10 1967	Month Day Year
5. SEX Fem	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 5 1878	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Secretary		11. BIRTHPLACE (County & State, or foreign country) Newport Penn	
13. FATHER'S NAME William Fleisher		14. MOTHER'S MAIDEN NAME Elizabeth Thatcher		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-44-848		17. INFORMANT Other record Address Mary Stella Fleisher	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chromobacillus faecal bacteria of brain.</i> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH 1 day</span> 4332 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Chrys. mycobacteris - mettling decompo-ans 1945</i> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Apr 1 1967</i> , to <i>Apr 10 1967</i> , that (I) (we) last saw the deceased alive on <i>Apr 1 1967</i> , and that death occurred at <i>121 M</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Howard Morse</i>		22b. DATE SIGNED <i>4/10/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>Howard T. Morse, M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>1030 Carrollville Takoma Park, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>April 13, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Newport Cemetery</i>	
24. FUNERAL DIRECTOR <i>Arthur Walters, 254 Carroll St NW Wash DC</i>		ADDRESS		23d. LOCATION (City, town or county) (State) <i>Newport Penna.</i>	
25a. REC'D BY REGISTRAR APR 13 1967		DATE		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

08820

12020

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05342 Items 8 & 9 Film CERTIFICATE OF DEATH 05340											
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY MONTGOMERY MARYLAND				b. STATE Wisconsin							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREEN BAY							
c. LENGTH OF STAY IN 1b 4-17-65 - 4-16-67				d. STREET ADDRESS							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Westwood Retirement Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED First ANTOINETTE Middle R. LYNN Last				4. DATE OF DEATH Month 4 Day 16 Year 1967							
F 6. COLOR OR RACE W				8. DATE OF BIRTH 1880 AGE (In years last birthday) 90 yrs.							
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				10. KIND OF BUSINESS OR INDUSTRY ---							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (County & State, or foreign country) Wisconsin							
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME MICHEL RESCH							
14. MOTHER'S MAIDEN NAME AMELIA FRANK				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO							
16. SOCIAL SECURITY NO. NO HE				17. INFORMANT ELEANOR FLYNN, 50, WINDERMERE ROAD Address WELLESLEY MASS.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 4201 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis. DUE TO (c)											
INTERVAL BETWEEN ONSET AND DEATH Several yrs.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Unknown.											
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N.A.							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				2de. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 4/16, 1967, to 4/16, 1967, that (I) (we) last saw the deceased alive on 4/4, 1967, and that death occurred at 10A.M. from the causes and on the date stated above.				22b. DATE SIGNED 16 April 1967.							
22a. SIGNATURE Rafael A. Borgos, M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) RAFAEL A. BORGOS.				22d. ADDRESS 2101-16 1/2 St., N.W., Washington, D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF 4-19-1967							
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Woodlawn Cemetery				23d. LOCATION (City, town or county) Green Bay, Wisc. (State)							
24. FUNERAL DIRECTOR GAWLER Wash. D.C.				25a. REC'D BY REGISTRAR APR 21 1967							
				25b. REGISTRAR'S SIGNATURE Charles Judge							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05343

Item #7 Film #05343 4/17/67 CERTIFICATE OF DEATH

05341

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Holy Cross Hospital - D.O.A.				13216 Silver Hill Road						
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
Francis Kilaare White				FLYNN	April	11	1967			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
Male	White			August 4, 1892	74 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Retired		Mechanic Engineer		Nebraska		U.S.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
James Flynn		Sarah Marion								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion										
4801 DUE TO Hypertensive Arterosclerotic Cardiovascular disease										
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Arteriosclerosis Generalized										
DUE TO										
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Colmar Manor	(County) Md.	(State) Md.			
21. I certify that (I) (this hospital) attended the deceased from 15 Feb 1967, to 11 apr 1967, that (I) (we) last saw the deceased alive on 1 Apr 1967, and that death occurred at 12:45 P.M., from the causes and on the date stated above.										
22a. SIGNATURE Thomas P. Fogarty										
22b. DATE SIGNED 11 Apr 67										
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								
		22d. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) (State)				
Cremation		4/17/1967		The Lincoln Cemetery Colmar Manor Md.						
24. FUNERAL DIRECTOR				ADDRESS		25a. READ BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
Arthur Walters		254 Carroll St N.W.		DATE		APR 13 1967	Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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05344

CERTIFICATE OF DEATH

05342

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>D.C.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b <i>11 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	b. COUNTY <i>Montgomery</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>	d. STREET ADDRESS <i>5103 Brookview Dr</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>KENNETH H. FOOTE</i>	First <i>KENNETH</i>	Middle <i>H.</i>	Last <i>FOOTE</i>			
4. DATE OF DEATH <i>April 24 1967</i>	Month <i>April</i>	Day <i>24</i>	Year <i>1967</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>11/11/00</i>	9. AGE (In years last birthday) <i>66</i>	Yrs. <i>66</i>	IF UNDER 1 YEAR Months <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Office Manager</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Electrical Equipment</i>	11. BIRTHPLACE (County & State, or foreign country) <i>New Hampshire</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Robert</i>	14. MOTHER'S MAIDEN NAME <i>Maryat Henry - above</i>	Address <i>111-03-864-Attn: Mrs. Henry, See Room #2</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>577-03-864-Attn: Mrs. Henry, See Room #2</i>	17. INFORMANT <i>John Smith, See Room #2</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i>						
DUE TO (b) <i>Massive Cerebral Thrombosis</i>						
DUE TO (c) <i>Cerebral Arteriosclerosis</i>						
INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Washington</i>	(County) <i>D.C.</i>	(State) <i>D.C.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>April 14</i> , 1967, to <i>April 24</i> , 1967, that (I) (we) last saw the deceased alive on <i>April 24</i> , 1967, and that death occurred at <i>3:45 PM</i> , from causes and on the date stated above.						
22a. SIGNATURE <i>Edward S. Witowski</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>April 24, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>DR. Edward S. Witowski</i>		22d. ADDRESS <i>8218-WISCONSIN AVE. N.W. WASH. D.C.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-27-1967</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek Cemetery</i>	23d. LOCATION (City or Town) <i>Washington, D.C.</i>	(County) <i>D.C.</i>	(State) <i>D.C.</i>
24. FUNERAL DIRECTOR <i>Joseph Gowler's Sons, Inc.</i>		ADDRESS <i>5130 Wisc. Ave. N.W., Wash. D.C.</i>	25a. REC'D BY REGISTRAR <i>MAY 2 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

882

3382

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05343

## CERTIFICATE OF DEATH

05345

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>8607 Mayfair Place</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First <i>Frank</i>		Middle <i>Filmore</i>		Last <i>Freeman</i>		4. DATE OF DEATH Month <i>April</i> Day <i>19</i> Year <i>1967</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/10/180</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Machinist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wash. Terminal Co.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		9. AGE (In years last birthday) <i>87 yrs.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>A 25 3125</i>		17. INFORMANT <i>Bessie B. Freeman</i>		Address <i>8607 Mayfair Place Silver Spring, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> DUE TO <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>{</i> (b) <i>Coronary Arteriosclerosis</i> DUE TO <i>{</i> (c) <i>{</i> INTERVAL BETWEEN ONSET AND DEATH <i>{</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. <i>Pulmonary Embolus at Lower Lobe</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>(County)</i> <i>(State)</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>17 Apr 1967</i> to <i>18 Apr 1967</i> , that (I) (we) last saw the deceased alive on <i>Apr 18 1967</i> , and that death occurred at <i>17 Apr 1967</i> M, from causes and on the date stated above.							
22a. SIGNATURE <i>James W. Eagan</i>		M.D. ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>JAMES W. EAGAN</i>		22d. ADDRESS <i>5413 CEDAR LANE, BETHESDA MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr 22, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince George's Co. Md.</i>	
24. FUNERAL DIRECTOR <i>John B. Warner</i>		ADDRESS <i>8434 Georgia Avenue</i>		25a. REC'D BY REGISTRAR <i>APR 26 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
20 M 1/66							

10280

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05346

## CERTIFICATE OF DEATH

05346

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**11 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institutional before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN b. <u>12 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home, 901 Arcola Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <u>Lewis</u> Middle <u>Cass</u> Last <u>Gabbert</u> (Type or print)		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1967</u>	
S. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1/21/1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
13. FATHER'S NAME <u>Benton Gabbert</u>		14. MOTHER'S MAIDEN NAME <u>Alice Layton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-54-8845</u>	
17. INFORMANT <u>Lewis C. Gabbert, Jr.</u>		Address <u>9201 2nd Avenue Silver Spring</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>4201</u> DUE TO <u>Death by myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <u>Chronic myocardial disease</u> DUE TO <u>Generalized arteriosclerosis</u> (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>95 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>St. Joseph</u> (County) <u>Missouri</u> (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/24/1967</u> to <u>4/3/1967</u> that (I) (we) last saw the deceased alive on <u>3/24/1967</u> , and that death occurred at <u>2:45 AM</u> , from causes and on the date stated above.		22b. DATE SIGNED <u>4-25-67</u>	
22a. SIGNATURE <u>John Rogers, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>John Rogers, M. D.</u>		22d. ADDRESS <u>1919 Seminary Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>April 6, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORIAL <u>Mt. Moriah Cemetery</u>		23d. LOCATION (City or Town) <u>St. Joseph</u> (County) <u>Missouri</u> (State)	
24. FUNERAL DIRECTOR <u>John B. Thomas, Thomas &amp; Warner, Inc.</u>		ADDRESS <u>8434 Georgia Avenue, Silver Spring, Md.</u>	
		25a. REC'D BY REGISTRAR <u>APR 7 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

PL850

PL850

Charles W. Egan - Dr. Rogers

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please leave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05347

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05345

1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN lb <i>17 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>DICKERSON, MD</i>		d. STREET ADDRESS <i>RT. #1 THURSTON RD</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Potomac Valley Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>William</i>	Middle <i>BRYCE</i>	Last <i>Galloway</i>	4. DATE OF DEATH <i>April 21 1967</i>	Month <i>April</i>	Day <i>21</i>	Year <i>1967</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-8-1883</i>	9. AGE (In years last birthday) <i>83</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SCHOOL TEACHER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>PUBLIC School</i>		11. BIRTHPLACE (County & State, or foreign country) <i>COSTBRIDGE Scotland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>JAMES GALLOWAY</i>				14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>480-30-3953</i>		17. INFORMANT <i>Charles E. Eggle</i>		Address <i>Rt. #1 Dickerson, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>		DUE TO <i>493X</i>				INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), <i>Fractures Rt Hip</i>		DUE TO <i>Generalized Arteriosclerosis</i>						
DUE TO <i>Fractures Rt Hip at Home in Hall 3/10/67</i>								
DUE TO <i>Fractures Rt Hip at Home in Hall 3/10/67</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fractures Rt Hip</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Fractures Rt Hip at Home in Hall 3/10/67</i>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>11/03 3-10 1967</i>		20d. INJURY OCCURRED While Nat While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, firm, factory, street, office bldg., etc.) <i>Fractures Rt Hip at Home in Hall 3/10/67</i>		20f. (City or town) <i>Frederick</i>		(County) <i>Fred.</i>		(State) <i>Md.</i>		
21. I certify that (I) ( <i>this hospital</i> ) attended the deceased from <i>1963</i> to <i>4/21 1967</i> , thot (I) ( <i>not</i> ) last saw the deceased alive on <i>4/21 1967</i> , and that death occurred at <i>3750 M.</i> from causes and on the date stated above.								
22a. SIGNATURE <i>James W. Egan</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <i>JAMES W. EGAN</i>		22d. ADDRESS		22e. DATE SIGNED <i>4/21/67</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-24-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Olivet Cem.</i>		23d. LOCATION (City or Town) <i>Frederick</i>		
24. FUNERAL DIRECTOR <i>Salamone Funeral Home</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
				DATE <i>APR 24 1967</i>				

02302

02315

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05348

## CERTIFICATE OF DEATH

05346

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY CORTLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 35 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cortland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 47 Hubbard Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JAMES		First	Middle	Last	4. DATE OF DEATH APRIL 20	Month	Day Year 19 67
S. SEX MALE	6. COLOR OR RACE CAUC.	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 14, 1946	9. AGE (In years last birthday) 20 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) U. S. MARINE CORP			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Cortland, New York	
13. FATHER'S NAME Anthony Galutz				14. MOTHER'S MAIDEN NAME Lena <input checked="" type="checkbox"/> Piedigrossi			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/> Service Party			16. SOCIAL SECURITY NO. 059 38 1587			17. INFORMANT Navy Records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND OF HEAD (Received as a result) INTERVAL BETWEEN ONSET AND DEATH 991X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) of action in Viet Nam DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 17 MAR 67, 19, to 20 APR 67, 19, that (I) (we) last saw the deceased alive on 20 APR 67, 19, and that death occurred at 11A.M. from causes and on the date stated above.							
22a. SIGNATURE <i>H. K. Roeder, C.R. MC. Cullinan</i>							
22b. DATE SIGNED 21 APR 67							
22c. PHYSICIAN'S NAME (Type) D. K. ROEDER		ATTENDING M.D. PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/> BETHESDA, MD	
23a. BURIAL, CREMATION, REMOVAL, ETC. Burial		23b. DATE THEREOF 4-24-67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Marys Cemetery		23d. LOCATION (City or Town) (County) (State) Cortland New York	
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin St., N. W. Washington, D.C.				25. REC'D BY REGISTRAR APR 25 1967		26. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

84830

07440-10

84830

UNIDENTIFIED PERSON (LATER) UNKNOWN

UNKNOWN UNKNOWN UNKNOWN UNKNOWN

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05349

## CERTIFICATE OF DEATH

05347

## 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN lb

2 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suburban Hospital

## 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Clarksburg

151

d. STREET ADDRESS

Greenvale Dr. P.O. Box 134

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)First  
MaryMiddle  
ALast  
Gilbert4. DATE  
OF  
DEATHMonth  
AprilDay  
14  
Year  
1967

5. SEX

Female

6. COLOR OR RACE

white

7. MARRIED

 NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

1/31/88

9. AGE (In years  
last birthday)

79 yrs.

10. IF UNDER 1 YEAR

Months  
Days  
Hours  
Min.10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (County &amp; State, or foreign country)

Kansas

12. CITIZEN OF WHAT  
COUNTRY?

USA

13. FATHER'S NAME

James

Hatchell

14. MOTHER'S MAIDEN NAME

Lydia

Crull

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

524-09-5750

17. INFORMANT

Husband  
George L. Gilbert

Address

Same as Item 2.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

576X

UREMIA

INTERVAL BETWEEN  
ONSET AND DEATH

4-5 days

Conditions, if any, which gave  
rise to immediate cause (a),  
stating the underlying cause  
last.

DUE TO

(b)

DUE TO

(c)

A acute Peritonitis

4-5 days

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 1920d. INJURY OCCURRED  
While  Not While   
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 4-12 1967 to 4-14 1967, that (I) (we) last  
saw the deceased alive on 4-13 1967, and that death occurred at 11:20 AM, from causes and on the date stated above.

22a. SIGNATURE

Delwitt E. DeLawter

M.D. ATTENDING  
PHYS. MED.  
DIRECTOR STAFF  
PHYS.

22b. DATE SIGNED

4-14-67

22c. PHYSICIAN'S  
NAME (Type)

Delwitt E. DeLawter

22d. ADDRESS

8025 ABERDEEN RD Bethesda MD

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial-transit 4-15-67

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

Howell Mem. Park

23d. LOCATION (City or Town)

(County)

(State)

West Plains, Missouri

24. FUNERAL DIRECTOR

ROBERT A. PUMPHREY, Bethesda, Maryland

ADDRESS

25a. REC'D BY REGISTRAR

APR 17 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge

78820

7/10/30 212100Z

78820

1  
FOR STATE  
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05350

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05348

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.		c. LENGTH OF STAY IN 1B		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		15/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 415 Silver Spring Avenue Apt 309				d. STREET ADDRESS 415 Silver Spring, Ave Apt. 309		e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle Joseph	Last Gilrain	4. DATE OF DEATH 4-21-67	Month 19	Day	Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVDRCED <input type="checkbox"/>	8. DATE OF BIRTH 12-1-1899	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contract Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME James J. Gilrain		14. MOTHER'S MAIDEN NAME Ellen Donaher					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None		17. INFIRMITY James Gilrain		Address Wagon Wheel Restaurant Worcester, Mass.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>acute myocardial disease</i>				INTERVAL BETWEEN ONSET AND DEATH 5 months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)					
		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 4-21-67	
ACTUAL SIGNATURE <i>John S. Rogers, M.D.</i>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		John S. Rogers, M.D., 1919 Seminary Rd., Silver Spring, Md. Address (Street, city, town, or county)					
23a. BURIAL, CREMATIION, REMDVAL (Specify) Trans-burial		23b. DATE THEREOF Apr 25, 1967		23c. NAME OF CEMETERY OR CEMATIORY St. Johns Cemetery		23d. LOCATION (City, town or county) Worcester, Mass. (State)	
24. FUNERAL DIRECTOR Glen Carter, Glen Carter, Inc. Warner E. Purnfrey, Inc.		ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR APR 27 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. Rogers</i>	
				DATE			

81638

06678

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05351

## CERTIFICATE OF DEATH

05349

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE		MARYLAND, MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b WHEATON 6-DAYS		b. COUNTY							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		UNIVERSITY NURSING HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		SILVER SPRING - 151					
3. NAME OF DECEASED (Type or print)		First Blanche	Middle Goldberg	Last Goldberg	4. DATE OF DEATH	Month 4	Day 15	Year 1967			
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-1882	9. AGE (in years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) NEWELTON LA.		12. CITIZEN OF WHAT COUNTRY USA					
13. FATHER'S NAME ABRAHAM SOLOMON		14. MOTHER'S MAIDEN NAME AMELIA DURNING									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 459-86-3525		17. INFORMANT MRST. W. FRIEDMAN - 806-MALCOLM-DR. S.S.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO ArTERIOSCLerotic Heart Disease 10 years		MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH INSTANT							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 19, 1967 to APRIL 19, 1967, that (we) last saw the deceased alive on 4/13 1967, and that death occurred at 12 noon, from the causes and on the date stated above.		22a. SIGNATURE Morton Shapiro		22b. DATE SIGNED 4/15/67							
22c. PHYSICIAN'S NAME (Type) MORTON SHAPIRO		22d. ADDRESS 8107-EASTERN AVE - S. S. MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/19/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Natchez Cemetery		23d. LOCATION (City, town or county) (State) Natchez, Mississippi					
24. FUNERAL DIRECTOR B Danzansky & Sons, 3501-14th St NW		ADDRESS		25a. REC'D BY REGISTRAR APR 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

03820

03820

0381 8 750

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**05352**

**CERTIFICATE OF DEATH**

**05350**

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md.		b. COUNTY Montg.		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Silver Spring 5½ bdayr		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		10213 McKenney Ave		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First John	Middle xxdead	Last GORKA	4. DATE OF DEATH	Month Apr	Day 19	Year 1967
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months 70 yrs.	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY		
Ret. Chef		Hammels Restaurant		Poland		U.S. A.		
13. FATHER'S NAME Paul Gorka		14. MOTHER'S MAIDEN NAME Ludwika Gorka						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> None		16. SOCIAL SECURITY NO. 578-01-7368A		17. INFORMANT Mrs Florence GORKA Silver Same		Address 10213 Mc Kenney Ave. Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion				1 min		
4/20/1		DUE TO (b)	Coronary Insufficiency			6 yrs		
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Mar 1967, to Apr 18, 1967, that (I) (we) last saw the deceased alive on Apr 18 1967, and that death occurred at 7:30 AM, from the causes and on the date stated above.								
22a. SIGNATURE John Lawrence Avery						22b. DATE SIGNED Apr 19, 1967		
22c. PHYSICIAN'S NAME (Type) John Lawrence Avery		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 10620 Georgia Ave. Silver Spring Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr 22 1967		23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery		23d. LOCATION (City, town or county) (State) Washington D.C.		
24. FUNERAL DIRECTOR John B. Thomas, John E. Warner & Son, Inc.		ADDRESS 434 Georgia Avenue				25a. REC'D BY REGISTRAR REC'D APR 26 1967		
						25b. REGISTRAR'S SIGNATURE Charles Judge		

Medical examiner's office notified JBL

02322

**FOR STATE  
HEALTH DERT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. *Page 5 may be retained for your files.*

**0 FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the S

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

Items 10a & B, 11, 12, 14 & 17 Film G 387 4/10/67 jm1

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05351

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Montgomery				a. STATE Maryland.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb		b. COUNTY Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Parking Lot Socks Department Store				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				15/1	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Day Year
Deborah			Wilds	Granger	APRIL 3 1967
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday) 34 yrs.
Fe	W-	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	June 28, 1932	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Easton, Mass.	
13. FATHER'S NAME Newlin D. Wildes				14. MOTHER'S MAIDEN NAME Faith Lovell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Michael Mulroney, 321 Duke St., Alexandria Va. H/P/HB3nd. Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Laceration & Maceration of Brain			
976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Gun Shot. Wound of Head. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH Sudden.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Shot Self. in RT Side of head with derringer 22 cal.			
20c. TIME OF INJURY Month, Day, Year Hour 2 3 p.m. 4/3 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) in Car	20f. (City or town) Bethesda	(County) (State) Montgomery
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John G. Ball</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 4/4/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF 4/5/1967	23c. NAME OF CEMETERY OR CREMATORIALy Cedar Hill Crematory	23d. LOCATION (City or Town) Suitland, Md.	(County) (State)
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Wash. DC		ADDRESS 5130 Wisconsin Ave. NW	25a. REC'D BY REGISTRAR APR 10 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

12550

11/16/1968

6000

monotony - University

1000-1500

Caenorhabditis

strongly

Entomophagous ticks are most abundant in the field.

C. elegans increased about 1000 fold

ye strains spot on W 5

Wardell

Caenorhabditis increased

about 1000 fold

host population density another tick

monotony decreased

monotony decreased

X

host population density

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05354

## CERTIFICATE OF DEATH

Reg. Dist. No. 05352

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery, MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington,</b>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bethesda-Silver Spring Nursing Home.</b>			d. STREET ADDRESS <b>4422 Q. Street, N.W.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Mary</b>			First <b>E.</b>	Middle <b>Hagan</b>	Last	4. DATE OF DEATH Month <b>April</b>	Day <b>20, 1967</b>	Year				
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 18, 1871</b>		9. AGE (In years last birthday) yrs. <b>96</b>	IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Dist. of Col.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
13. FATHER'S NAME <b>Robert DeLay</b>			14. MOTHER'S MAIDEN NAME <b>Wallace</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>578-48-4096</b>			17. INFORMANT <b>Grand-Daughter</b> Address <b>Mrs. Logan E. Hill Wash. D.C.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>585X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause lost. <b>Circumstances</b> DUE TO (c)											INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.	Month <b>March</b>	Day <b>19</b>	Year <b>1967</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>4740 Chevy Chase Dr</b>	(County) <b>Prince Georges Co.</b>	(State) <b>Maryland</b>				
21. I certify that I attended the deceased from <b>22 March 1967</b> to <b>20 April 1967</b> , that I last saw the deceased alive on <b>15 Apr 1967</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.											ADDRESS (Street, city or town, state) <b>4740 Chevy Chase Dr</b>	DATE SIGNED <b>21 Apr 67</b>
ACTUAL SIGNATURE <b>Herbert Martyn</b>			M.D. <b>4740 Chevy Chase Dr</b>									
PHYSICIAN'S NAME (Type) <b>HERBERT MARTYN Jr</b>			Chevy Chase MD									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 25, 1967</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cem.</b>			22d. LOCATION (City, town, or county) <b>Prince Georges Co., Maryland</b>			(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Non. Devol</b>			ADDRESS <b>2222 Wis. Ave. N.W.</b>		24a. REC'D BY REGISTRAR <b>APR 28 1967</b>			24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				
VS A15 (4) 1SM 9/SS			Washington, D.C. 20007		DATE							



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>				3. NAME OF DECEASED (Type or print) <u>Helen</u>				
b. CITY OR TOWN outside corporate limits, write RURAL and give nearest town <u>Takoma Park</u>				c. LENGTH OF STAY IN lb <u>DOA</u>				d. CITY OR TOWN outside corporate limits, write RURAL and give nearest town <u>Takoma Park,</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hospt.</u>				e. STREET ADDRESS <u>4 Domer Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH		Month	Day	Year				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-11</u>		9. AGE (In years last birthday) <u>56</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Lueke</u>		14. MOTHER'S MAIDEN NAME <u>Mary Knoke</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Dan T. Halifax (same as #2)</u>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Acute intracranial hemorrhage</u> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Essential hypertension</u> DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Baltimore</u> (County) <u>Maryland</u> (State) <u>Maryland</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>BELDEN R. READ, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (State, city, town, or county)												
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE THEREOF <u>Burial May 3, 1967</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Lakewood Cemetery</u>		23d. LOCATION (City or Town) <u>Baltimore</u> (County) <u>Maryland</u> (State) <u>New York</u>						
24. FUNERAL DIRECTOR <u>J. Arthur Wallace, 254 Carroll St NW Wash DC</u>		ADDRESS <u>8 Arthur Wallace, 254 Carroll St NW Wash DC</u>		REC'D BY REGISTRAR <u>RECOFT</u> DATE MAY 1 1967		REGISTRAR'S SIGNATURE <u>Charles Judge</u>						

66620

RECEIVED IN LIBRARY 1969-07-10

66622

1969-07-10 YAM

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05354

05356			CERTIFICATE OF DEATH						05354				
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> (town)			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>										
			c. LENGTH OF STAY IN 1b <b>1 Hour</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b> 1511							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>			d. STREET ADDRESS <b>Kinross</b> <b>10103 Kenross Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>William</b>			First	Middle	Last	4. DATE OF DEATH		Month	Doy	Year			
5. SEX		6. COLOR OR RACE	7. MARRIED		NEVER MARRIED	8. DATE OF BIRTH		9. AGE (In years lost birthday)		IF UND 1 YEAR	IF UND 24 HRS		
<b>Male</b>		<b>White</b>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<b>7-16-84</b>		<b>82 yrs.</b>		Months	Doy	Hours	Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired--Insurance Agent</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Louisville, Ky.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Michael Hanlon</b>						14. MOTHER'S MAIDEN NAME <b>Catherine Lyons</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>			16. SOCIAL SECURITY NO. <b>579-30-2171</b>			17. INFORMANT <b>William L. Hanlon, Son, 403 Lexington Dr. SS</b>			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>				
(b) <b>Myocardial insufficiency</b> DUE TO (c) <b>Arteriosclerotic hypertensive cardiovascular disease</b>									<b>1 year</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.			19										
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1967</b> , to <b>April 1, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 1, 1967</b> , and that death occurred at <b>5:35 P.M.</b> from causes and on the date stated above.												22b. DATE SIGNED <b>4-1-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Raymond Bradshaw</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS <b>345 University Blvd. W., S. S., Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Apr 5, 1967</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co., Md.</b>				
24. FUNERAL DIRECTOR <b>John B. Thomas</b> <b>John Blom</b> <b>8434 Georgia Avenue</b> <b>Warner E. Pumphrey, Inc.</b> <b>Silver Spring, Md.</b>						25a. RECEIVED BY REGISTRAR <b>APR 7 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

CLEARED WITH MEDICAL EXAMINER/gm

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Items 18-21 Film 388 5-2 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05357

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05355

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		d. STREET ADDRESS <b>8007 TAKOMA AVE.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSP.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>LOWELL</b>	Middle <b>(NONE)</b>	Lost <b>HARDIN</b>	4. DATE OF DEATH <b>APRIL 18, 1967</b>	Month <b>18</b>	Doy <b>18</b>	Year <b>1967</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>JAN. 1. 1917</b>	9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED ARMY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ARMED FORCES</b>		11. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>DAVID HARDIN</b>				14. MOTHER'S MAIDEN NAME <b>CORA</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> <b>WWII + KOREA</b>		16. SOCIAL SECURITY NO. <b>315 10 0052</b>		17. INFORMANT <b>S.S. POLICE &amp; MRS L. HARDIN (WIFE)</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>976X</b>		DUE TO <b>Gunshot wound, upper right chest,</b>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>{</b>		(b) <b>apparently self-inflicted</b>							
DUE TO <b>{</b>		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased in poor health and despondent - shot self with shotgun</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>00:00</b> p.m. <b>4 - 18 19 67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
				20f. (City or town) <b>silver Spring</b>		(County) <b>Montg</b>		(State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Belden R. Read</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. READ M.D.</b>		Address <b>Arlington National Cemetery</b>		22. DATE SIGNED <b>4/18/1967</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 21, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cemetery</b>		23d. LOCATION (City or Town) <b>Arlington</b>		(County) (State) <b>Virginia</b>	
24. FUNERAL DIRECTOR <b>Arthur Walters, 254 Carroll St NW DC</b>		ADDRESS <b>Arthur Walters, 254 Carroll St NW DC</b>		25a. REC'D. BY REGISTRAR <b>APR 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Belinda J. Geiger</b>			

56510

PROJET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05358

## CERTIFICATE OF DEATH

05356

1. PLACE OF DEATH a. COUNTY <i>Mont. Co.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN lb <i>23 days.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>	d. b. COUNTY <i>Mont. Co.</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>S'buryan</i>		d. STREET ADDRESS <i>4419 - Walsh st.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Helen</i>	Middle <i>E.</i>	Last <i>Haydon</i>
4. DATE OF DEATH Month <i>April</i>	Day <i>22</i>	Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>12/26/90</i>
9. AGE (In years lost birthday) yrs. <i>76</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>stenographer</i>	11. BIRTHPLACE (County & State, or foreign country) <i>New York</i>	12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>
13. FATHER'S NAME <i>J.P. Gustafson</i>	14. MOTHER'S MAIDEN NAME <i>Margaret Bennett</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>no</i>	17. INFORMANT <i>Charles J. Haydon.</i>	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i>		INTERVAL BETWEEN ONSET AND DEATH DAYS <i>Peritonitis, acute</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Inflam. myocardia, massive</i>		DAYS <i>Mesenteric thrombosis, massive</i>	
DUE TO (b) <i>Arteriosclerosis, severe</i>		YEARS <i>Arteriosclerosis, severe</i>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Inflam. myocardia, massive</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>injury</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <i>(City or town) (County) (State)</i>
21. I certify that (I) (this hospital) attended the deceased from <i>3-30</i> , 19 <i>67</i> , to <i>4-22</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4-22</i> , 19 <i>67</i> , and that death occurred at <i>627</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Robert G. Brewer</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>Robert G. Brewer</i>		22d. ADDRESS <i>8505 Old Georgetown Rd. Bethesda, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>4-26-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Rock Creek Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	ADDRESS <i>P.O. Box 1166</i>	25a. REG'D BY REGISTRAR <i>APR 28 1967</i>	25b. REC'D BY SIGHT <i>Robert G. Brewer</i>

02326

22322

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #23c &amp; d Film #G108 5/8/67 pc

## CERTIFICATE OF DEATH

05357

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>T.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>4 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Saburb am</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C.</i>	
d. STREET ADDRESS <i>2725-39th St. N.W.</i>		d. STREET ADDRESS <i>473</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>J. Joseph E. Henderson</i>		First <i>J.</i>	Last <i>Henderson</i>
4. DATE OF DEATH <i>April 17 1967</i>	Month <i>Apr.</i>	Day <i>17</i>	Year <i>1967</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/29/09</i>
9. AGE (In years last birthday) yrs. <i>57</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Scientist</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farm Service</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Fisher, Minn</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>Charles F. Henderson</i>	14. MOTHER'S MAIDEN NAME <i>Louisa Siebross</i>	Address <i>Grand Folks, N.D. Hansen Anderson, 115-5 5th St.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>110-00-0000</i>	17. INFORMANT <i>Hansen Anderson</i>	18. INTERVAL BETWEEN ONSET AND DEATH moments <i>4 days</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>			
DUE TO <i>190X</i>			
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <i>Heart Failure</i>			
DUE TO <i>190X</i>			
(c) <i>Pneumonia, Bilateral</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>115-5 5th St.</i>		(County) (State) <i>Grand Folks, N.D.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>sep 19 66</i> to <i>APR 17 1967</i> , that (I) (we) last saw the deceased alive on <i>Apr 17 1967</i> , and that death occurred at <i>115-5 5th St.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>DeWitt E. DeLawter</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <i>DeWitt E. DeLawter MD</i>		22d. ADDRESS <i>3848 Porter SW Wash DC.</i>	23d. LOCATION (City or Town) (County) (State) <i>Grand Folks, N.D. Fisher, Minn.</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>4-19-1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Fisher Cemetery</i>
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons Inc.</i>		ADDRESS <i>5130 Wisconsin Ave. N.W. Wash. DC.</i>	25a. REC'D BY REGISTRAR DATE <i>APR 20 1967</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

02321

1960 TO 1961

Items 10&21 Film 389 6-8-MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STAFF  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH						05358
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Dist. of Col.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>			c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash. San + Hosp.</i>			e. STREET ADDRESS <i>1851 Frederick Pl., S.E.</i>			
3. NAME OF DECEASED (Type or print) <i>James Jerry Henson</i>			First	Middle	Last	
4. DATE OF DEATH Month <i>4</i> Day <i>7</i> Year <i>1967</i>						
5. SEX <i>M</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>5-31-34</i>		9. AGE (In years last birthday) <i>32 yrs.</i>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>			10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <i>Dist. of Col.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Amos Henson</i>			14. MOTHER'S MAIDEN NAME <i>Josephine Thomas</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> <i>Our Force</i>			16. SOCIAL SECURITY NO. <i>51-53 579-48-387</i>			
17. INFORMANT <i>Marjorie Henson - 203 N St., S.E.</i>			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary insufficiency</i> DUE TO <i>4201</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary artery heart disease</i> DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) <i>Baltimore</i> (County) <i>M.D.</i> (State) <i>M.D.</i>						
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Belden R. Reap</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22. DATE SIGNED <i>APRIL 7 1967</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>4/13-67</i>		23b. DATE THEREOF <i>4/13-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL CENTER <i>ALEXANDRIA NATIONAL Cemetery</i>		
23d. LOCATION (City or Town) <i>ALEXANDRIA</i> (County) <i>VA.</i> (State) <i>VA.</i>						
24. FUNERAL DIRECTOR <i>Rhines Funeral Home.</i>		ADDRESS		25a. RECD BY REGISTRAR <i>APR 13 1967</i>		
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

112928

112928

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X

112928

112928

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05361

05359

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>15 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		d. STREET ADDRESS <b>2715 RANDOLPH Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2715 RANDOLPH Road</b>				d. STREET ADDRESS <b>2715 RANDOLPH Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RUTH HELEN HIERLING</b>		First	Middle	Last	4. DATE OF DEATH Month <b>APRIL</b>	Day <b>2</b>	Year <b>1967</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 1, 1922</b>	9. AGE (In years last birthday) yrs. <b>44</b>	IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARVEY DELONG</b>		14. MOTHER'S MAIDEN NAME <b>ANTOINETTE KAHLERT</b>		Address (SAME) <b>2715 Randolph Rd., S. S.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Yes</b>		ROBERT A. HIERLING (HUSBAND)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Generalized Carcinomatosis due to Metastasis from Carcinoma of the Cervix.				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (He/She/It) attended the deceased from <b>January 15, 1967</b> to <b>April 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 15, 1967</b> and that death occurred at <b>8:35 AM</b> M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Belden R. Reap</b>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>APRIL 3, 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		22d. ADDRESS <b>Wheaton, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 5, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John B. Thomas</b>		ADDRESS <b>8434 Georgia Avenue</b>		25a. REC'D BY REGISTRAR <b>APR 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
VR A15 (4) 1SM 9/59							

22630

1945-2000-00002

22630

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05362

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05360

1. PLACE OF DEATH  
a. COUNTY

Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring Died on arrival

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Holy Cross Hosp - Silver Spring  
Forest Glade Rd

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

b. COUNTY

Maryland Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Wheaton 151

d. STREET ADDRESS

2610 Weller Rd

e. IS RESIDENCE  
ON A FARM?  
YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First Middle

Last

4. DATE  
OF  
DEATH

Month

Day Year

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED

WIDOWED

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

6/19/29

Months Days

Hours Min.

37

yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

Housewife At Home

11. BIRTHPLACE (State or foreign country)

WASH. D.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Louis L. COLLIE

14. MOTHER'S MAIDEN NAME

EMMA V. HATCHER

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

229-34-3694 MONTGOMERY E. HIGGINS - SAME AS #2

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Acute Heart Disease due to massive coronary thrombosis  
4201 DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)  
DUE TO  
(c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  
None

INTERVAL BETWEEN  
ONSET AND DEATH  
1 hr.

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

2. MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m.

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

John S. Rogers, M.D.

Montgomery Reg. 1967

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address Street, city, town, or county

22. DATE SIGNED  
4-20-67

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

BURIAL 4/24/67 Mt. Comfort Cem.

ADDRESS

5130 WIS. AVE. N.W.

Jes. GANLON'S SONS, WASHINGTON, D.C.

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE APR 26 1967

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02360

54610

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

05363

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05361

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Mont. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md.	c. LENGTH OF STAY IN D. Suburban	b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 117-3		
3. NAME OF DECEASED First Dorothy Middle B. Last Hines	4. DATE OF DEATH April 19 1967	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
S. SEX female	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New singing classist		10b. KIND OF BUSINESS OR INDUSTRY Government	9. AGE (In years lost, birthday) 4 yrs.
13. FATHER'S NAME Sylvester Cole		11. BIRTHPLACE (State or foreign country) Washington, D.C., U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 577-32-2759	17. INFORMANT John Hines-husband Address 1230 Queen St
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism. Massive RT Lung Sudden.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombosis of Veins of Left Leg days? (c) Trauma of Left leg. 5 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall - getting off Bus - and strained Left ankle	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 8:30 a.m. 3/11 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg, etc.) Street -
20f. (City or town) (County) (State) Washington - DC -			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John S. Bell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) 4/17/67	
23a. BURIAL, CREMATION, REMOVAL (Specify Burial)		23b. DATE THEREOF 14/24/67	
23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial Ceme.		23d. LOCATION (City or Town) Maryland	
24. FUNERAL DIRECTOR John T. Stewart, Attorney		25a. RECD. BY REGISTRAR APR 20 1967	
Stewart Funeral Home-4001 Benning Rd.,		25b. REGISTRAR'S SIGNATURE Charles Judge	

102301

51201

A 212

active on water

also in sea

12 days 1927 - found south Rio Grande  
in the mud - mud bottom & gravelly  
bottom - probably sand bottom  
above - → probably current

X

about 100 miles from - and following the

100 miles - 100 miles X X X X X

100 miles X

Barrowland

100 miles 100 miles 100 miles 100 miles 100 miles 100 miles

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05364

## CERTIFICATE OF DEATH

05362

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			b. COUNTY <i>Montgomery</i>		
c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross</i>			d. STREET ADDRESS <i>4407 Independence St.</i>		
3. NAME OF DECEASED (Type or print)		First <i>Hodgdon</i>	Middle <i>Hodgdon</i>	Last <i>Hodgdon</i>	4. DATE OF DEATH <i>April 16 1967</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>4-16-67</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs. <i>13</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Montgomery Co., Maryland USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		10. MOTHER'S MAIDEN NAME <i>Ruby Lee Hamn</i>	
13. FATHER'S NAME <i>George Harrison Hodgdon</i>		14. INFORMANT <i>Father</i>		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Term Birth, NEONATAL Death</i> DUE TO <i>1620</i>				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>FETAL Anoxia</i> DUE TO					
(c) <i>Ruptured Vterus</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Georgetown Doctors Park</i>	(County) <i>Celar Lane, Bethesda, Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>4-16 1967</i> to <i>4-16 1967</i> , that (I) (we) last saw the deceased alive on <i>4-16 1967</i> , and that death occurred at <i>11:58 PM</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>Brockett Muir</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <i>April 17 1967</i>	22c. PHYSICIAN'S NAME (Type) <i>Brockett Muir</i>	22d. ADDRESS <i>Georgetown Doctors Park</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/21/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven</i>	23d. LOCATION (City or Town) <i>Silver Spring, Md.</i>	(County) (State)
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home-1331 Rockville Pike</i>		ADDRESS <i>Rockville, Md.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE <i>APR 24 1967</i>

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

05365

**CERTIFICATE OF DEATH**

05363

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>37 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. STREET ADDRESS <b>Box 199-E, Route 1</b>			
3. NAME OF DECEASED (Type or print) <b>Donald Curtis Holden</b>		4. DATE OF DEATH <b>April 7 1967</b>	Month Day Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 January 1950</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years last birthday) <b>17 yrs.</b>
13. FATHER'S NAME <b>Earl C. Holden</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-56-1099</b>	17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda, Maryland</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <i>2000</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Pancytopenia</b> DUE TO (b) <b>Reticulum Cell Sarcoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>14 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		5 Weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town) (County) (State)</b>
21. I certify that (I) (this hospital) attended the deceased from <b>1 March 1967</b> , to <b>7 April 1967</b> , that (I) (we) lost saw the deceased alive on <b>7 April 1967</b> , and that death occurred of <b>7:00 M</b> , from causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE <i>Myron J. Levin</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>8 April 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>Myron J. Levin, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/11/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Marymisco</b>
24. FUNERAL DIRECTOR <i>Anthony E. Ward Caskets Md</i>		ADDRESS	25. DEPT BY REGISTRATION <b>APR 11 1967</b>
		DATE	26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**11 TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon borders. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>05366</b>		<b>CERTIFICATE OF DEATH</b>		<b>05364</b>	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Muncaster Mill Rd.</u>		<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>Muncaster Mill Rd.</u>		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
<b>3. NAME OF DECEASED</b> <u>Evelyn Jean</u> First <u></u> Middle <u></u> Last <u>Holland</u> (Type or print)		<b>4. DATE OF DEATH</b> <u>22 April</u> Month <u>April</u> Day <u>22</u> Year <u>1967</u>			
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR FACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		<b>8. DATE OF BIRTH</b> <u>Nov. 3, 1924</u> <b>9. AGE (In years last birthday)</b> <u>42</u> yrs.	
<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>	
<b>13. FATHER'S NAME</b> <u>Thomas Holland</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ethel Winslow</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Throat</u>				INTERVAL BETWEEN ONSET AND DEATH	
118X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) DUE TO (c)			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Sandy Spring</u> <b>20f. (City or town)</b> <u>Sandy Spring</u> <b>(County)</b> <u>Md.</u> <b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept. 1967</u> <b>to</b> <u>April 1967</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>22 April 1967</u> <b>and that death occurred at</b> <u>Sandy Spring</u> <b>M.</b> <b>from causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>R.A. Butler</u>		<b>M.D.</b> <input checked="" type="checkbox"/> <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>23 April 1967</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>R.A. Butler</u>		<b>22d. ADDRESS</b> <u>2710 Norbeck Road, Silver Spring, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>Apr. 27, 1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORIAL</b> <u>Ash Memorial Cem.</u>	
<b>24. FUNERAL DIRECTOR</b> <u>Robert L. Snowden Rockville, Md.</u>		<b>ADDRESS</b>		<b>25a. REC'D BY REGISTRAR</b> <u>DA</u> <b>MAY 2</b> <b>1967</b>	
				<b>26b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05367

## CERTIFICATE OF DEATH

05365

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Handled by Medical Examiner*

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			c. LENGTH OF STAY IN lb <i>17 hrs.</i>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton, Md.</i>			d. STREET ADDRESS <i>University Nursing Home</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>Mamie</i>	Middle <i>T.</i>	Last <i>Holloway</i>	4. DATE OF DEATH Month <i>8</i> Day <i>9</i> Year <i>1967</i>
5. SEX <i>f</i>		6. COLOR OR RACE <i>Negro</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/2/1890</i>
9. AGE (In years lost birthday) <i>76 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (County & State, or foreign country) <i>No. Carolina U.S.A.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <i>WILLIAM TATE</i>			14. MOTHER'S MAIDEN NAME <i>EMMA ?</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>VIVIAN T. BOGGS</i> Address <i>6717-13 Place NW</i>	
18. CAUSE OF DEATH (Enter only one cause per line, for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Acute Pulmonary Edema &amp; Cva</i> INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) <i>Arteriosclerotic Cerebrovascular Disease</i> <i>april 5, 1967</i> stating the underlying cause (c) <i>Old Age</i> <i>Silver Spring</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Chronic Lung Disease</i>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <i>fall</i>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>april 7, 1967</i> to <i>april 9, 1967</i> , that (I) (we) last saw the deceased alive on <i>april 9, 1967</i> , and that death occurred at <i>578 M</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>april 10, 1967</i>			
22a. SIGNATURE <i>Rex Bufalino</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>april 10, 1967</i>
22c. PHYSICIAN'S NAME (Type) <i>R.C. Bufalino, M.D.</i>		22d. ADDRESS <i>1429 University Blvd NW Silver Spring</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-12-1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Violet Hill</i>	23d. LOCATION (City or Town) (County) (State) <i>Asheville N.C.</i>	
24. FUNERAL DIRECTOR <i>Holy R. Fisher</i>		ADDRESS <i>W. Ernest Marvin Co.</i>	25a. REC'D BY REGISTRAR <i>APR 13 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles George</i>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

95368

CERTIFICATE OF DEATH

05366

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. **Please remove carbon papers.** **Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>100 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Enterprise</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>				d. STREET ADDRESS <b>R.D. # 1</b>				
25 3. NAME OF DECEASED (Type or print)		First <b>Cheryl</b>	Middle <b>Aileen</b>	Last <b>Holt</b>	4. DATE OF DEATH <b>April 21 1967</b>	Month <b>April</b>	Day <b>21</b>	Year <b>1967</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>6 October 1945</b>	9. AGE (In years last birthday) <b>21 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Kenneth P. Holt</b>				14. MOTHER'S MAIDEN NAME <b>Helen Cogan</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>The Medical Records</b> Address <b>Not available</b>		The Clinical Center, Bethesda, Maryland 20014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory insufficiency</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> 2893 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchiectasis</b> unknown (c) <b>Cystic fibrosis</b> since birth								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <b>(s)</b> (this hospital) attended the deceased from <b>Jan. 11, 1967</b> , to <b>April 21, 1967</b> , that <b>(s)</b> (we) last saw the deceased alive on <b>April 21, 1967</b> , and that death occurred at <b>10:45M</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>David N. Soghore</b>		M.D. ATTENDING MED. P.M. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>April 22, 1967</b>				
22c. PHYSICIAN'S NAME (Type) <b>David N. Soghore, M.D.</b>		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/25/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Grandview Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Altoona, Pennsylvania</b>		
24. FUNERAL DIRECTOR <b>Tyson "heeler Funeral Home-1331 Rockville Pike</b>		ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 25 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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RADIO TRANSMISSION

202

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**05369**

**CERTIFICATE OF DEATH**

**05367**

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>22 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbridge</b> 833				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>903 Essex Drive</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>Vaughn</b>		First	Middle	Lost	4. DATE OF DEATH <b>April 27 1967</b>	Month	Doy	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>1927 December 11,</b>	9. AGE (In years last birthday) <b>40 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. US OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jess Holt</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Martin</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1946-1964</b>		16. SOCIAL SECURITY NO. <b>335 24 2001</b>		17. INFORMANT <b>Woodbridge Mrs. Gladys Holt, 903 Essex Drive</b>		Address <b>Virginia</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HODGKINS DISEASE</b>								INTERVAL BETWEEN ONSET AND DEATH
201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Apr. 6 1967</b> , to <b>Apr. 27, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Apr. 27 1967</b> , and that death occurred at <b>1120</b> , from causes and on the date stated above.								
22a. SIGNATURE <i>R. J. Kinney</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>APRIL 29, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>R. J. Kinney</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-2-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>			23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>		
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Home</b> ADDRESS <b>7557 Wisconsin Ave., Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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1949-10-11 1949-10-11

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH				05368			
1. PLACE OF DEATH a. COUNTY      Mpntgomery Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      Silver Spring c. LENGTH OF STAY IN lb      D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)      Holy Cross Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE      Virginia b. COUNTY      Fairfax c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      Falls Church			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED      First      Middle      Lost Emil      Frederick      Holtz				4. DATE OF DEATH      Month      Day April 7, 1967			
S. SEX      Male	6. COLOR OR RACE      White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH      December 4, 1930	9. AGE (in years lost birthday)      36 yrs.	IF UNDER 1 YEAR      Months	IF UNDER 24 HRS.      Days	
10. DO. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House Home construction Unknown				Pittsburg, Penna.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Emil E. Holtz				Sarah King			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)      Yes		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
				Beglinger Funeral Home		1008 Chartiers Ave. Pittsburg, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a)      8194		Acute, extreme, multiple Fractures of skull with exsanguination					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b)		Fractures of skull with					
(c)		exsanguination					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of injury in Part I or Part II of item 18.) Decceased driver of truck struck over person support on Rte 495 near La. Ave.					
20c. TIME OF INJURY Month, Day, Year 3 45 p.m. 4-7 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Baltimore Rte 495		20f. (City or town) (County) (State) Silver Spring Montgomery Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town or County) Belden R. Reap M.D.					
22. DATE SIGNED April 7, 1967							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) (County) (State)	
Trans-Burial		Apr 11, 1967		Oakland Cemetery		Pittsburg, Penna.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Glen Carter Warner E. Pumphrey, Inc.		8434 Georgia Avenue Silver Spring, Md.		APR 11 1967		<i>Charles Judge</i>	

80560

RECEIVED  
LIBRARY OF CONGRESS  
JULY 1962

63831

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05371

CERTIFICATE OF DEATH

05359

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ednor</b> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First <b>William</b> Middle <b>Arthur</b> Last <b>Hood</b>		4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1967</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-18-98</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Post Office</b>		9. AGE (In years last birthday) <b>69</b> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Charles R. Hood</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT</b>	
		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Embolism</b> DUE TO <b>8 hr. post-op Leg Amputation</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis Obliterans</b> DUE TO <b>Latent Diabetes Mellitus.</b> Years <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Nephrosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>p.m.</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>1947</b> (County) <b>1967</b> (State) <b>Jun 26</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 26 1967</b> , to <b>Jun 26 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 26 1967</b> , and that death occurred at <b>3:10 P.M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>4/26/67</b>	
22a. SIGNATURE <b>Richard A. Yates, M.D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD A. YATES, M. D.</b>		22d. ADDRESS <b>OLNEY, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/29/67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Sandy Spring Cem.</b>		23d. LOCATION (City or Town) <b>Sandy Spring, Md</b> (County) <b>Md</b> (State)	
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b> ADDRESS <b>Rockville, Md</b>		25a. REC'D BY REGISTRAR <b>MAY 2 1967</b> DATE <b>1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

00620

1960-10-14 10:00:00

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05372

CERTIFICATE OF DEATH

05370

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		b. COUNTY <b>MONTGOMERY</b>		
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5600 SPRINGFIELD DRIVE</b>		d. STREET ADDRESS <b>5600 SPRINGFIELD DRIVE</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>ANNA</b>	Middle <b>MARIE</b>	Last <b>HOPKINS</b>	
4. DATE OF DEATH	Month <b>April</b>	Month <b>2</b>	Doy <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH <b>MARCH 2, 1902</b>	
9. AGE (In years lost birthday) <b>65</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Nurse</b>	11. BIRTHPLACE (County & State, or foreign country) <b>IRELAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>AUSTIN CLANCY SR.</b>	14. MOTHER'S MAIDEN NAME <b>MARY HAYES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>578-56-8024</b>	17. INFORMANT <b>Dr. Gerald A. Hopkins 5600 Springfield Dr.</b>	Address <b>Bethesda, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Carcinoma of lung</b> DUE TO 163X Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>13 mos.</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) _____				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) _____		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>March 1966 to April 21, 1967</b>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 1966 to April 21, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 20, 1967</b> , and that death occurred at <b>4A M.</b> from causes and on the date stated above.				22b. DATE SIGNED <b>4/21/67</b>
22c. PHYSICIAN'S NAME (Type) <b>E.W.NICKLAS</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS <b>4830 - V St. N.W. Wash. D.C.</b>		22b. DATE SIGNED <b>4/21/67</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/24/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cemetery Silver Spring, Montgomery Md.</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons 5130 Wisc. Ave. N.W.</b>		ADDRESS <b>Wash. D.C.</b>	25a. REC'D BY REGISTRAR <b>APR 26 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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STUDY

THREE TOWNS

CLIMATE

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WIND SPEED

EVAPORATION AND WIND SPEED

WIND DIRECTION

WIND SPEED

WIND DIRECTION

Wind direction and speed

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**05373**

**CERTIFICATE OF DEATH**

**05371**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH <b>a. COUNTY</b> Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) <b>a. STATE</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		d. STREET ADDRESS 4133 New Hampshire Ave. N.W.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitarium 10231 Carroll Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>WILLIAM</b>	Middle <b>Frank</b>	Last <b>HORTMAN</b>	4. DATE OF DEATH <b>APRIL 18</b>	Month <b>APRIL</b>	Day <b>18</b>	Year <b>1967</b>
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/26/85</b>	9. AGE (In years last birthday) <b>81 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>	12. IF UNDER 24 HRS. Minutes <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <b>Plate printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bureau of Printing &amp; Engraving</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Stewart Hortman</b>		14. MOTHER'S MAIDEN NAME <b>Louella Metz</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>578-52-4235</b>		17. INFORMANT <b>Nellie I. Hortman same as #2</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>								
DUE TO <b>444X</b>								
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ESSENTIAL HYPERTENSION</b>								
DUE TO								
(c) <b>GENERALIZED ARTERIOSCLEROSIS</b>								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>SENILITY</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>White at work</b>								
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year <b>19</b>	20d. INJURY OCCURRED Not White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>APRIL 12, 1966</b>	(County) <b>APRIL 18, 1967</b>	(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>APRIL 12, 1966</b> , to <b>APRIL 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>APRIL 18, 1967</b> ; and that death occurred at <b>10:12 A.M.</b> , from the causes and on the date stated above.								
22a. SIGNATURE <b>Henry M. Lowden</b>								
22b. DATE SIGNED <b>APRIL 18, 1967</b>								
22c. PHYSICIAN'S NAME (Type) <b>Henry M. Lowden</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <b>5206 Norway Dr., Chevy Chase, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4/20/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Glenwood Cemetery</b>		23d. LOCATION (City, town or county) <b>Washington, D.C.</b>		
24. FUNERAL DIRECTOR <b>The S.H. Hines Co.</b>		ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>APR 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**M**

**05374**

**CERTIFICATE OF DEATH**

**05372**

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Montgomery</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>6 hrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>4005 Plym mill Rd</i>	
3. NAME OF DECEASED (Type or print) <i>Lillian</i>		First <i>Howard</i>	Middle <i>Howard</i>
4. SEX <i>m</i>	5. COLOR OR RACE <i>c</i>	6. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/>
7. DATE OF DEATH <i>April 28</i>	8. DATE OF BIRTH <i>5/30/86</i>	9. AGE (In years last birthday) <i>80</i>	10. IF UNDER 1 YEAR Months <i>0005</i>
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	13. FATHER'S NAME <i>Milton Howard</i>	14. MOTHER'S MAIDEN NAME <i>Mullie?</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Elsie Outlaw</i>	Address <i>10005 Eastern Ave</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i> DUE TO <i>4201</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Was 7-8 hrs</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Coronary Atherosclerosis</i>		UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>NONE</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1015 Spring St</i>
20f. (City or town) <i>SILVER SPRING, MD</i>		(County) <i>SILVER SPRING, MD</i>	(State) <i>MD</i>
21. I certify that (I) (this hospital) attended the deceased from <i>APRIL 28, 1967</i> , to <i>APRIL 28, 1967</i> , that (I) (we) last saw the deceased alive on <i>APRIL 28, 1967</i> , and that death occurred at <i>131A M</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Edward A. Beeman</i>		22b. DATE SIGNED <i>APRIL 29, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>EDWARD A. BEEMAN</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22d. ADDRESS <i>1015 Spring St</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 3, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Ash Memorial</i>
24. FUNERAL DIRECTOR <i>Robert L. Snider, Rachelle</i>		ADDRESS <i>md</i>	25a. REC'D BY REGISTRAR DATE <i>MAY 5 1967</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles J. Snider</i>

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05375

## CERTIFICATE OF DEATH

05373

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		d. STREET ADDRESS <b>13313 Wye Oak Drive, Route 3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>William</b>	Middle <b>Charles</b>	Lost	4. DATE OF DEATH <b>April 5</b>	Month <b>April</b>	Day <b>5</b>	Year <b>1967</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <b>WIDOWED</b>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>January 3, 1931</b>	9. AGE (In years lost birthday) <b>36 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Building Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Earl R. Howarth</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Grant</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>1948-1952</b>		16. SOCIAL SECURITY NO. <b>Not available</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral Hemorrhage</b>						INTERVAL BETWEEN ONSET AND DEATH <b>22 hours</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>204.3</b>		(b) <b>Acute Myelogenous Leukemia</b>				4 weeks			
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <b>Jerry L. Spivak</b> attended the deceased from <b>April 1, 1967</b> , to <b>April 5, 1967</b> , that <b>I</b> (we) last saw the deceased alive on <b>April 5, 1967</b> , and that death occurred at <b>5:25 PM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>Jerry L. Spivak</b>						22b. DATE SIGNED <b>6 April 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Jerry L. Spivak, M.D.</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <b>Jerry L. Spivak, M.D.</b>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/8/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Darnestown Church Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Darnestown, Maryland</b>			
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DATE R 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05374

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove carbon paper~~. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M		05376		05374	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
o. COUNTY <b>Montgomery</b>		o. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN lb <b>26 days</b>		b. COUNTY <b>Montgomery</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS <b>16000 Batson Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Leonard</b>		First <b>Samuel</b>	Middle <b>Howes</b>	4. DATE OF DEATH <b>April 2 1967</b>	Month Doy Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/6/14</b>	9. AGE (In years at birthday) <b>52 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Repairman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bottling Company</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Samuel Howes</b>		14. MOTHER'S MAIDEN NAME <b>Grace Howes</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>                        </b>		17. INFORMANT <b>Hospital Records</b>	
18. MEDICAL CERTIFICATION		Address			
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) (c)		<b>PULMONARY EDEMA</b> <b>UREMIA - CHRONIC RENAL INSUF 5 YRS+</b> <b>HYPERTENSIVE CARDIOVASC. DIS YES.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). <b>CEREBRAL EDEMA : METABOLIC ACIDOSIS</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m.      p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work      of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>                        </b>	
20f. (City or town) <b>                        </b>		(County) <b>                        </b>		(State) <b>                        </b>	
21. I certify that <b>①</b> (this hospital) attended the deceased from <b>FEB. 1967</b> , to <b>2 APRIL 1967</b> , that <b>①</b> (we) last saw the deceased alive on <b>3 APRIL 1967</b> , and that death occurred at <b>1:30 PM</b> from causes and on the date stated above.		22. DATE SIGNED <b>3 APRIL '67</b>			
22a. SIGNATURE <b>Ronald R. Lewis</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. PHYSICIAN'S NAME (Type) <b>D. R. LEWIS</b>		22d. ADDRESS <b>Sandy Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-5-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Burtonsville</b>	
23d. LOCATION (City or Town) <b>Burtonsville, Md.</b>		(County) <b>                        </b>		(State) <b>                        </b>	
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>		ADDRESS <b>Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 4 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 10 Page 4 may be retained by the hospital or attending physician.  
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

05377

CERTIFICATE OF DEATH

05375

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2111 Hildarose Drive</b>		e. STREET ADDRESS <b>2111 Hildarose Drive</b>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Catherine</b>		First <b>Catherine</b>	Middle <b></b>	Last <b>Hudson</b>	4. DATE OF DEATH Month <b>April</b>	Doy <b>30</b>	Year <b>19 67</b>	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS. Days <b></b>
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input type="checkbox"/> <b></b>	NEVER MARRIED DIVORCED <input type="checkbox"/> <b></b>	8. DATE OF BIRTH <b>Sept 9, 1898</b>	9. AGE (In years last birthday) <b>68 yrs.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Trimming Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bureau of Print.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George L. Yoe</b>		14. MOTHER'S MAIDEN NAME <b>Emma Mahaney</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>577-56-0526 A</b>		17. INFORMANT <b>Bernard A. Hudson</b>		<b>2111 Hildarose Drive</b> <b>Silver Spring, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b></b>		DUE TO <b></b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Rheumatoid Arthritis</b>				INTERVAL BETWEEN ONSET AND DEATH <b></b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> <b></b>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 1, 1967</b> to <b>April 30, 1967</b> that (I) (we) last saw the deceased alive on <b>April 30, 1967</b> and that death occurred at <b>9 A.M.</b> from causes and on the date stated above.									
22a. SIGNATURE <b>John J. Curry</b>		M.D. ATTENDING PHYS. <b>A</b>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/30/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>John J. Curry</b>		22d. ADDRESS <b>10620 Georgia Ave. S.S. Rd.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 3, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>St. John's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Forest Glen, Maryland</b>			
24. FUNERAL DIRECTOR <b>John B. Thomas &amp; Sons Inc.</b>		ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 4 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

05378

## CERTIFICATE OF DEATH

05376

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi Park</u>			c. LENGTH OF STAY IN lb <u>D.O.A.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <u>Lenore</u>	Middle <u>B.</u>	Lost	4. DATE OF DEATH <u>Hungerford</u>	Month <u>April</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>May 17, 1908</u>	9. AGE (In years lost birthday) <u>75 yrs.</u>	IF UNDER 1 YEAR Months <u>0</u>
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Music</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	IF UNDER 24 HRS. DAYS <u>0</u>
13. FATHER'S NAME <u>Millard Brownlee</u>			14. MOTHER'S MAIDEN NAME <u>Frances Mc Caleb</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>			16. SOCIAL SECURITY NO. <u>089-78-9533-A</u>	17. INFORMANT <u>Charles G. Hungerford</u>	Address <u>9709 23rd Avenue Adelphi, Maryland</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>(Probable) Acute Myocardial Infarction</u> INTERVAL BETWEEN Conditions, if any, which gave onset and death rise to immediate cause (a), stating the underlying cause <u>Arteriosclerotic Heart Disease</u> seconds lost. (b) DUE TO <u>2 1/2 yrs.</u> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I(o) <u>Hypertension, Obesity, Arteriosclerosis generalized</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Jan. 7, 1966</u>	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 7, 1966</u> to <u>present</u> , (I) (we) last saw the deceased alive on <u>13 March 1967</u> , and that death occurred at <u>8:05 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Frederick J. Barr</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4-12-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Frederick J. Barr</u>		22d. ADDRESS <u>4500 College Ave., College Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>Apr 15, 1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Forest Hill Cemetery</u>	23d. LOCATION (City or Town) <u>Utica, New York</u>	(County) (State)
24. FUNERAL DIRECTOR <u>Paul E. Smith</u>		ADDRESS <u>8434 Georgia Avenue</u>	25a. REC'D BY REGISTRAR <u>DATE 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
20 M 1/66					

27820



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**05379**

**CERTIFICATE OF DEATH**

**05377**

**1. PLACE OF DEATH**

a. COUNTY

*Montgomery*

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

*Silver Springs* 2 Months 8 Days

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

*Fairland Nursing Home*

3. NAME OF  
DECEASED  
(Type or print)

First      Middle

Last      Month      Day      Year

*Catherine Teresa Hurley*

*April*

*5 1967*

5. SEX

6. COLOR OR RACE

*Female white*

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

*August 15, 1892*

9. AGE (in years  
last birthday)

*74 yrs.*

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*File Clerk - Retired*

10b. KIND OF BUSINESS OR  
INDUSTRY

*Insurance*

11. BIRTHPLACE (County & State, or foreign country)

*Brockton, N.Y.*

12. CITIZEN OF WHAT  
COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Father's John J. Hurley*

14. MOTHER'S MAIDEN NAME

*Aguilla M. Webb*

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown)  (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

*060-01-33624*

17. INFORMANT

*John J. Hurley - See Item #2*

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

*Arteriosclerotic heart disease*

*260X*

INTERVAL BETWEEN  
ONSET AND DEATH

Conditions, If any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

*Diabetes mellitus*

*10 yrs*

*(b)*

*DUE TO*

*(c)*

*DUE TO*

*(c)*

*Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)*

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While  Not While

at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on

*4-4 1967*

and that death occurred at

*3A M.*

from the causes and on the date stated above.

22a. SIGNATURE

*R.C. Kirchner*

22b. DATE SIGNED

*4-5-67*

M.D. ATTENDING PHYS.  M.D. DIRECTOR  STAFF PHYS.

22c. PHYSICIAN'S NAME (Type)

*R.C. KIRCHNER*

22d. ADDRESS

*Takoma Park,*

*6480 New Hampshire Ave. M.D.*

23a. BURIAL, CREMATION, REMOVAL (Specify)

*Removal*

23b. DATE THEREOF

*4-7-1967*

23c. NAME OF CEMETERY OR CREMATORIUM

*St. Charles Cemetery Long Island, N.Y.*

23d. LOCATION (City, town or county) (State)

*Long Island, N.Y.*

24. FUNERAL DIRECTOR

*Joseph Gawler's Sons, Inc.*

5130 Wisconsin Ave. N.W. Wash. DC.

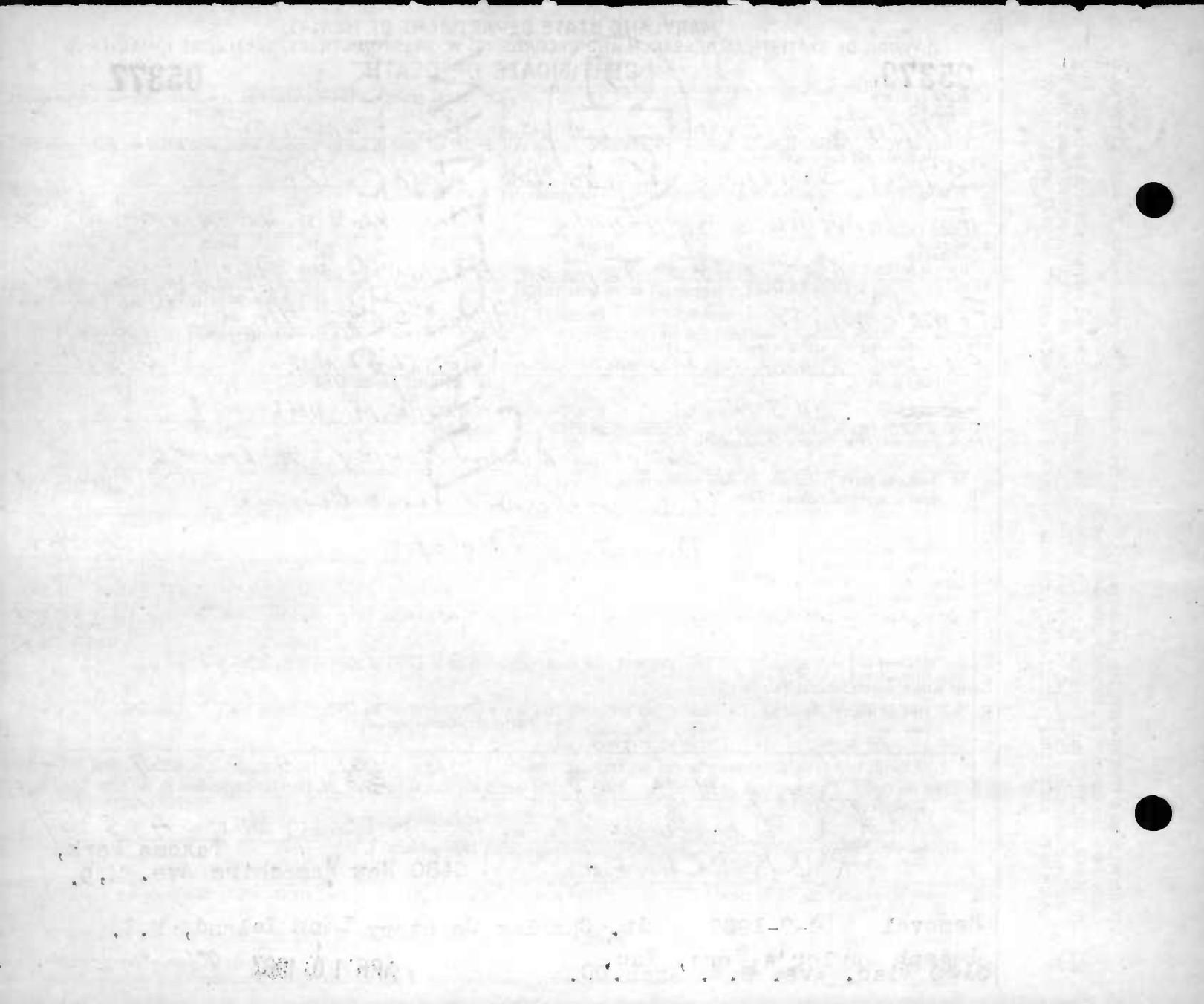
25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE

*APR 10 1967*

*Charles Judge*



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #11, 13 &amp; 14 infor taken from birth cert.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05373

FOR STATE  
HEALTH DEPT.

If any delay is  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm  
PM.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of  
Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.  
5 may be retained for your files.

VR A15ME (5)  
6M 1/66

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb <b>5 mins.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Oak</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>11301 Stewart Lane</b>	
3. NAME OF DECEASED (Type or print) <b>Baby Girl Hyson</b>		First <b>Baby</b>	Middle <b>Girl</b>
SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/> <input type="checkbox"/>
8. DATE OF BIRTH <b>10, Apr, 67</b>		9. AGE (In years lost birthday) yrs. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>White Oak, Mont. Co.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Bill Smith</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Wilkinson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7735</b> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>April 11, 1967</b>	
ACTUAL SIGNATURE <i>Belden R. Reap</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>	M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/12/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Sale of Heaven</b>	23d. LOCATION (City or town) (County) (State) <b>Silver Spring, Md.</b>
24. FUNERAL DIRECTOR <b>Tyson Wheeler - Rockville, Md.</b>	ADDRESS	25a. REC'D BY REGISTRAR <b>APR 13 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. Moore</b>

9-124437

82328

U.S. GOVERNMENT

PRINTING

DEPT. OF COMMERCE

460-0001

UNITED STATES GOVERNMENT

STANDARD FORM

1600-10000

10-1967-01

REPLACES EDITION OF 1964

U. S. GOVERNMENT

PRINTING

460-0001

1600-10000

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05381

## CERTIFICATE OF DEATH

05379

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>			c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b> <b>901 Arcola Avenue</b>			e. STREET ADDRESS <b>Washington</b> <b>2400 19th St., N.W., Apt. 104</b>		
3. NAME OF DECEASED (Type or print) <b>William</b>			First <b>Andrew</b>	Middle <b>Irwin</b>	4. DATE OF DEATH <b>APRIL 22 1967</b>
S. SEX <b>male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <b>WIDOWED</b>	NEVER MARRIED <b>DIVORCED</b>	B. DATE OF BIRTH <b>1884</b>	9. AGE (In years lost birthday) <b>82 yrs.</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>teacher of theology</b>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) <b>Markdale, Ontario, Canada</b>			12. CITIZEN OF WHAT COUNTRY? <b>Canada</b>		
13. FATHER'S NAME <b>Henry D. Irwin</b>			14. MOTHER'S MAIDEN NAME <b>Mary Anne Cunningham</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>458-50-7028-A</b>		17. INFORMANT <b>NURSING HOME RECORDS -</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive Heart failure</b> DUE TO <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>arteriosclerotic Ht. disease 3 mos.</b> DUE TO lost. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Ca of the prostate suspected.</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Washington</b>	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Apr. 22, 1967</b> , to <b>April 22 1967</b> , that (I) (we) last saw the deceased alive on <b>Apr. 22, 1967</b> , and that death occurred at <b>11:00 A.M.</b> from causes and on the date stated above.					
22o. SIGNATURE <b>S. J. RANDALL</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>APR. 22 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>S. J. RANDALL, M.D.</b>		22d. ADDRESS <b>3001 VEAZLEY TERR. N.W. D.C.</b>			
23o. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-22-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>GEORGETOWN Univ. MED. School</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON D.C.</b>	
24. FUNERAL DIRECTOR <b>James E. DeVal</b>	ADDRESS <b>Wash. D.C.</b>	25a. REC'D BY REGISTRAR <b>MAY 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

07550

WASH TO STATION

22310

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05380

CERTIFICATE OF DEATH

05382

*M.L. White b.d. covering her P. Benard & D. Tannin illness*  
 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>D.C.</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		c. LENGTH OF STAY IN lb <i>42 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		d. STREET ADDRESS <i>2101 16th St NW</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Randolph Hills Nursing Home</i>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <i>NAUM</i>		First	Middle	Last	4. DATE OF DEATH <i>JASNY</i>	Month	Day Year <i>4 - 22 - 1967</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/25/1883</i>	9. AGE (In years last birthday) <i>84 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Economist</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State, or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Michael</i>		14. MOTHER'S MAIDEN NAME <i>Rosa</i>					
15. WAS DECLASSED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>546-44-2486A</i>		17. INFORMANT <i>Mrs. Milton Moss</i>		Address <i>8564 WHITTIER BLVD. BETHESDA, MD.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4/16 X</i>		DUE TO <i>Armenia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>		(b) DUE TO <i>Nephrosclerosis</i>				<i>2 yrs</i>	
		(c) DUE TO <i>Generalized arterio-sclerosis</i>				<i>15 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				CVA			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>				20c. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20d. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <i>Merton L. White</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>MERTON L. WHITE</i>		22d. ADDRESS <i>9911 Georgia Ave Silver Spring</i>		22e. DATE SIGNED <i>22 Aug 1967</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE THEREOF <i>4/24/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>CEDAR HILL CREM.</i>		23d. LOCATION (City or Town) (County) (State) <i>SUITLAND, MD.</i>	
24. FUNERAL DIRECTOR <i>Jos. GAWLER'S SONS, 3130 W. St. N.W. WASH. DC</i>		ADDRESS		25a. REG'D BY REGISTRAR <i>APR 26 1967</i>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>	

02380

KODAK SAFETY FILM

02380

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05383

CERTIFICATE OF DEATH

05381

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>1 hr 10 min</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		d. STREET ADDRESS <i>10422 Fawcett St</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary</i>		First <i>Elizabeth</i>	Middle <i>Jean</i>
4. DATE OF DEATH Month <i>April</i> Day <i>20</i> Year <i>1967</i>		Last <i>71</i>	
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>13/2/95</i>
9. AGE (In years lost birthday) <i>71 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (County & State or foreign country) <i>Co. New Bern</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles W</i>		14. MOTHER'S MAIDEN NAME <i>Louisie Chick</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-26-9604</i>	
17. INFIRMITY <i>Husband James John Kensington Md</i>		Address <i>10422 Fawcett St</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i> DUE TO <i>Metastatic carcinoma -</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Prominent carcinomatous fibroblast</i> (b) <i>Metastatic carcinoma -</i> DUE TO <i>Prominent carcinomatous fibroblast</i> (c) <i>Prominent carcinomatous fibroblast</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>190X</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>Jan 19</i> p.m. <i>67</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Rockville</i> (County) <i>Maryland</i> (State) <i>Md.</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1967</i> , to <i>Apr 20 1967</i> , that (I) (we) last saw the deceased alive on <i>4-18 1967</i> , and that death occurred at <i>200 W. from causes and on the date stated above.</i>			
22a. SIGNATURE <i>R. Thibadeau</i>		22b. DATE SIGNED <i>Apr 20 67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert t. Thibadeau</i>		22d. ADDRESS <i>11,000 old Georgetown Rd. Rockville Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr. 21, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>
24. FUNERAL DIRECTOR <i>J. Green Cartel Ellen Carter, Warner E. Pumphrey, Inc.</i>		ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>	23d. LOCATION (City or Town) <i>Rockville, Maryland</i> (County) <i>Maryland</i> (State) <i>Md.</i>
		25a. DATE <i>APR 27 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05384

CERTIFICATE OF DEATH

05382

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after the funeral.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>19 days</b>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b>	b. COUNTY <b>Fairfax</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reston</b>		d. STREET ADDRESS <b>1702 Shagbark Circle</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
e. DATE OF DEATH First <b>Carl</b>		Middle <b>Emerson</b>	Last <b>Johnson</b>	Month <b>April</b>	Day <b>11</b>	Year <b>1967</b>				
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 November 1920</b>	9. AGE (In years last birthday) <b>46 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Louis Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Alberta Coles</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>1942-45, 1952-54</b>		16. SOCIAL SECURITY NO. <b>098-12-2493</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda, Maryland 20014</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<b>Cardiorespiratory collapse</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>1979</b>		(b) <b>Severe Glucose Deficiency</b>		12 hours						
DUE TO <b>Severe Glucose Deficiency</b>		(c) <b>Fibrosarcoma</b>		2 years						
DUE TO <b>Fibrosarcoma</b>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (1) (this hospital) attended the deceased from <b>March 23, 1967</b> , to <b>April 11, 1967</b> , that (2) (we) last saw the deceased alive on <b>April 11, 1967</b> , and that death occurred at <b>5:00 P.M.</b> from causes and on the date stated above.										
22a. SIGNATURE <b>Joel Rubenstein</b>						P		22b. DATE SIGNED <b>12 March 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Joel Rubenstein, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/14/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Grace Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Birmingham, Ala.</b>				
24. FUNERAL DIRECTOR <b>Alexis Glenn</b>		ADDRESS <b>Greene Funeral Home, 814 Franklin St. Alexandria</b>		25a. REC'D BY REGISTRAR <b>APR 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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10:00 AM 5/14/2020

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**3**  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #9 Film #G387 1/11/67 pg

05385

CERTIFICATE OF DEATH

05383

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>D. C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arlington</i>		c. LENGTH OF STAY IN TB <i>8 mo 10 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kensington GARDENS</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Clara</i>	Middle <i>E. S. Johnson</i>	Last 4. DATE OF DEATH Month <i>APRIL</i> Day Year <i>7 1967</i>
S. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 4 1869</i> AGE (In years 98 last birthday) <i>38</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>homemaker</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (County & State, or foreign country) <i>INDIANA</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>GEORGE S. Johnson</i>	14. MOTHER'S MAIDEN NAME <i>Clara Burbank</i>	17. INFORMANT Address <i>Fred BEYER 129 12th St. S.E. D.C.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>	16. SOCIAL SECURITY NO. <i>UNKNOWN</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>585X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Chronic (+ acute) cholecystitis</i> (b) DUE TO (c)	
INTERVAL BETWEEN INJURY AND DEATH <i>22 hrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>12-7</i>
21. I certify that (I) (this hospital) attended the deceased from <i>4-3 1967</i> to <i>4-7 1967</i> , that (I) (we) last saw the deceased alive on <i>4-3 1967</i> , and that death occurred at <i>10P.M.</i> from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE <i>G.F. Sengstack MD</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>4-7-67</i>
22c. PHYSICIAN'S NAME (Type) <i>G.F. Sengstack</i>		22d. ADDRESS <i>9241 Columbia Blvd. Silver Spring Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>		23b. DATE THEREOF <i>Apr. 8, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>CEDAR Hill Crematory 5730 Wisconsin Ave. N.W. Wash. D.C.</i>
24. FUNERAL DIRECTOR <i>Joseph Gowler Sons</i>		25a. RECD BY REGISTRAR <i>APR 12 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05386

CERTIFICATE OF DEATH

05384

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		05386		CERTIFICATE OF DEATH		
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>Montgomery</b>		a. STATE <b>Maryland</b>		b. COUNTY <b>P.G. Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN lb <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		d. STREET ADDRESS <b>7409 Aspen Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED <b>LAWRENCE</b>		First	Middle	Lost	4. DATE OF DEATH <b>April 20 1967</b>	
				Month	Day Year	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <b>XX</b>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Sept. 8, 1918</b>	9. AGE (In years last birthday) <b>48 yrs.</b>	
		<b>WIDOWED <input type="checkbox"/></b>	<b>DIVORCED <input type="checkbox"/></b>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>H. Rush</b>		14. MOTHER'S MAIDEN NAME <b>Thomas Johnson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW2 212-14-1895</b>		17. INFORMANT <b>Mrs. Tressa C. Johnson</b>		Address <b>same</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:		<b>Cardiac Arrest</b>			<b>30 Min.</b>	
IMMEDIATE CAUSE (a) <b>1920</b>						
DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		<b>Acute Myocardial Infarction</b>			<b>30 Min.</b>	
(b) DUE TO						
(c) DUE TO		<b>Acute Coronary Thrombosis</b>			<b>30 Min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<b>Arterosclerotic Cardiovascular Disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Takoma Park</b> (County) <b>Montgomery Co. Md.</b> (State) <b>MD</b>
21. I certify that (1) this hospital attended the deceased from <b>Sept 1966</b> , to <b>April 1967</b> , that (2) we last saw the deceased alive on <b>19</b> , and that death occurred at <b>1:35 AM</b> , from causes and on the date stated above.						
22a. SIGNATURE <b>Wilford D. Meyers M.D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 20, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Wilford D. Meyers M.D.</b>		22d. ADDRESS <b>8323 Haddon Drive Takoma Park MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 22, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>George Washington</b>		23d. LOCATION (City or Town) <b>Adeleche, Md.</b> (County) <b>Montgomery Co. Md.</b> (State) <b>MD</b>
24. FUNERAL DIRECTOR <b>Charles Dally</b>		ADDRESS <b>254 Carroll St NW</b>		25a. REC'D BY REGISTRAR <b>APR 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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CONFIDENTIAL - COMMERCIAL - 1970 - COMMERCIAL - 1970 - COMMERCIAL - 1970

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05385

05387		MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> <i>MARYLAND</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>MARYLAND</i> b. COUNTY <i>Montgomery</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i>		c. LENGTH OF STAY IN 1b <i>DOA</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i>		d. STREET ADDRESS <i>10518 Weymouth St</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>														
3. NAME OF DECEASED (Type or print)		First <i>Jc Hn</i>	Middle <i>Kenneth</i>	Last <i>Jones</i>	4. DATE OF DEATH <i>April 11, 1967</i>		Month <i>April</i>	Doy <i>11</i>	Year <i>1967</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>		
5. SEX <i>m</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-11-1909</i>		9. AGE (In years last birthday) <i>64</i>	yrs. <i>0</i>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Author</i>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>John</i>			<i>Jones</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>Yes Navy</i>			16. SOCIAL SECURITY NO. <i>378-30-7669</i>			17. INFORMANT <i>Wife Iris D. Jones</i>			Address <i>Same as Item 2.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>4201</i> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.			DUE TO (b) DUE TO (c)			<i>Coronary Insufficiency Acute</i> <i>Cardio Vascular Disease</i>			INTERVAL BETWEEN DEATH AND DEATH <i>0 hr</i> <i>years</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>														
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>John G. Ball</i> M.D. EXAMINER'S NAME (Type) <i>John G. Ball</i>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>4-17-67</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Alexandria Natl Cem.</i>			23d. LOCATION (City or Town) (County) (State) <i>Alexandria, Virginia</i>					
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>			ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>			25a. REC'D BY REGISTRAR DATE <i>APR 13 1967</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

28860

100% of the time

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Item 18 Film 388 5-5-67 a MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05388

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05386

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>4 lbs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		d. STREET ADDRESS <i>12102 Livingston St</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hosp of St. Spg.</i>				d. STREET ADDRESS <i>151</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Gertrude Mac</i>		First	Middle	Lost	4. DATE OF DEATH <i>Katz</i>	Month	Doy	Year	
S. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-29-07</i>	9. AGE (in years lost birthday) <i>60 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>DC</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>			
13. FATHER'S NAME <i>Robert Gladmon</i>		14. MOTHER'S MAIDEN NAME <i>Gertrude Reed</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No None</i>		16. SOCIAL SECURITY NO. <i>215-46-4495</i>		17. INFORMANT <i>Col. Irvin J. Katz</i>		Address <i>12102 Livingston St. Wheaton, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4201</i>		IMMEDIATE CAUSE (a) <i>Acute myocardial disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost.</i>		DUE TO (b) <i>Myocardial rupture and cardiac Tamponade</i>				1 hr.			
		DUE TO (c) <i>Acute myocardial infarction</i>				8-9 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Arlington</i>		(County) (State) <i>(County) (State)</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John S. Rogers MD</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <i>4-20-67</i>	
EXAMINER'S NAME (Type) <i>John S. Rogers MD</i>		ADDRESS <i>1718 Belmont Rd., Silver Spring, Md.</i>		23d. LOCATION (City or Town) <i>Arlington, Virginia</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr 25, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington Nat'l Cemetery</i>		23d. LOCATION (City or Town) <i>Arlington, Virginia</i>			
24. FUNERAL DIRECTOR <i>John B. Thomas</i>		ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 27 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles George</i>			
VR A15ME (5) 6M 1/66									

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**1 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

05389

## CERTIFICATE OF DEATH

05387

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Rockville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Rockville</i>			
c. LENGTH OF STAY IN 1b <i>1b</i>				d. STREET ADDRESS <i>12316 Mc Crossin Lane</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>12316 Mc Crossin Lane</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Leslie</i>	Middle <i>Davis</i>	Lost <i>Keller</i>	4. DATE OF DEATH <i>April 6</i>	Month <i>April</i>	Year <i>1967</i>
S. SEX <i>H</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 17 1883</i>	9. AGE (In years birthday) <i>83</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (County & State, or foreign country) <i>Unknown</i>	
13. FATHER'S NAME <i>?</i>				14. MOTHER'S MAIDEN NAME <i>Keller</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mr W.W. Moats - Item #2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Atherosclerosis Coronary</i> DUE TO (c) <i>Arterio Sclerotic</i> INTERVAL BETWEEN ONSET AND DEATH <i>Var</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Bethesda</i>	(County) <i>Montgomery Co.</i>	(State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1965</i> , to <i>April 6, 1967</i> , that (I) (we) last saw the deceased alive on <i>30 March 1967</i> , and that death occurred on <i>23 April 1967</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>W.M. S. Murphy</i>				22b. DATE SIGNED <i>April 6, 1967</i>			
22c. PHYSICIAN'S NAME (Type) <i>W.M. S. Murphy</i>		22d. ADDRESS <i>Rockville, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/9/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Preston Chapel</i>	23d. LOCATION (City or Town) <i>Stafford Co. Va.</i>		(County) <i>Stafford Co.</i> (State) <i>Va.</i>	
24. FUNERAL DIRECTOR <i>Funeral Director - 1331 Rockville Pike Rockville, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>APR 7 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

T2E30

C2E30



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05380

05388

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Cleared - with Medical Examiner*

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>6 hours 45 min</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>228 Thistle Drive</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital of Silver Spring</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <i>Thomas</i> Middle <i>S</i> Lost		4. DATE OF DEATH Month <i>4</i> Doy <i>2</i> Year <i>1967</i>	
5. SEX <i>Male</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5/19/61</i>	
9. AGE (In years lost birthday) <i>5 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert F. Kempf</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Welmeyer</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Robert F. Kempf</i>		Address <i>228 Thistle Drive, Silver Spring, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral edema</i> INTERVAL BETWEEN ONSET AND DEATH 092X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Acute yellow atrophy of liver</i> lost. DUE TO (c) <i>Viral hepatitis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>6-16, 1967</i> , to <i>April 2, 1967</i> that (I) (we) last saw the deceased alive on <i>April 2, 1967</i> , and that death occurred at <i>12:45 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Carolyn S. Pincock</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>4/3/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Carolyn Pincock, M.D.</i>		22d. ADDRESS <i>1944 Seminary Rd., Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr 6, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR <i>John B. Thomas, John B. Thomas &amp; Son, Inc., Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>APR 7 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

82660

UFCG

2021-01-01 00:00:00

David Campbell

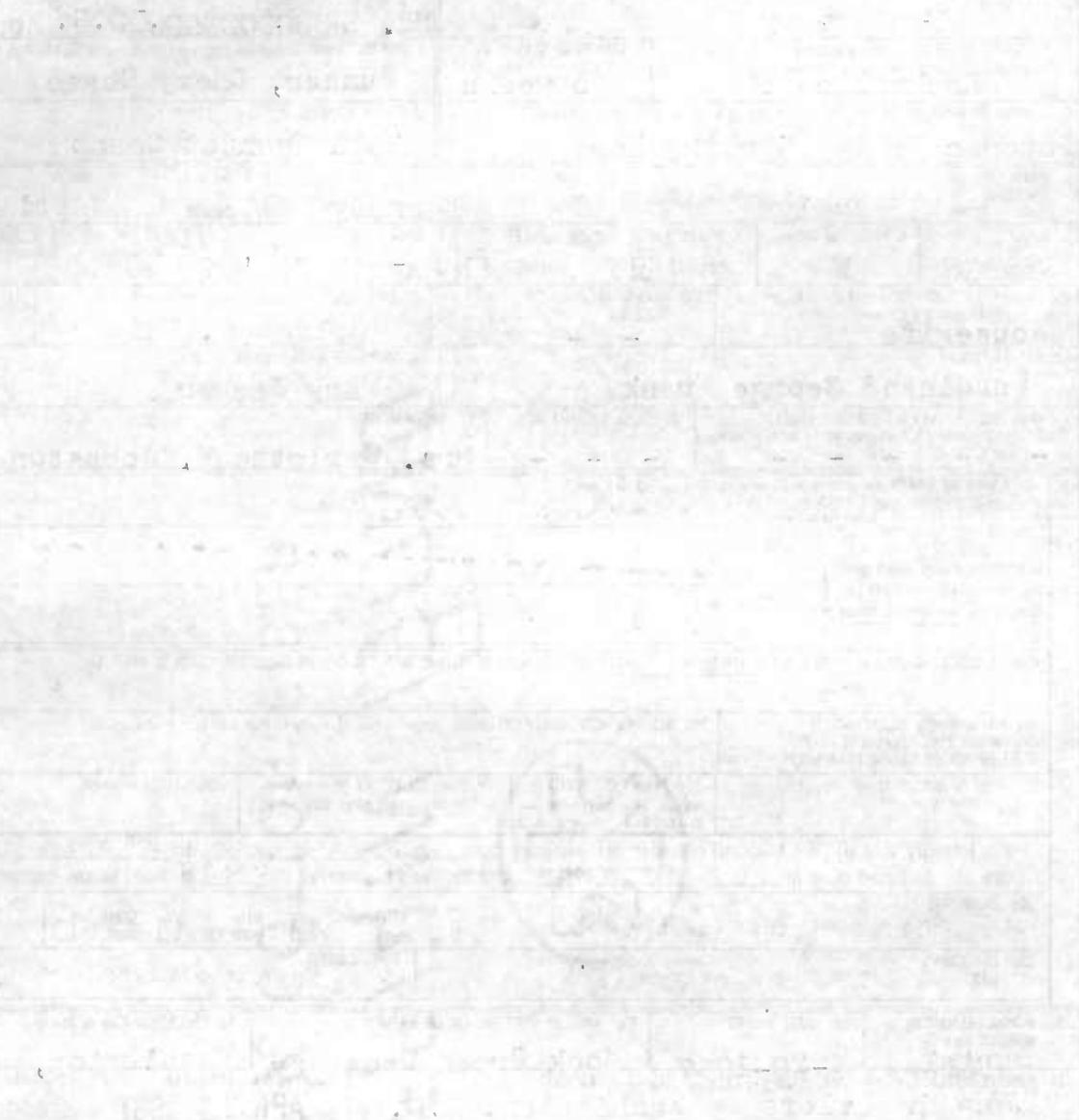
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05391						CERTIFICATE OF DEATH					
						05389					
1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Washington, D.C.</b> Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			c. LENGTH OF STAY IN 1b <b>6 weeks</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sumner, Chevy Chase</b>			d. STREET ADDRESS <b>5016 Wyandot Court</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Valley Nursing Home</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Evelyn</b>	Middle <b>S</b>	Last <b>Kennedy</b>	4. DATE OF DEATH <b>April 17 1967</b>	Month <b>April</b>	Doy <b>17</b>	Year <b>1967</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 22 1981</b>	9. AGE (In years last birthday) <b>85 yrs.</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Columbus, Ohio</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Ferdinand George Frank</b>						14. MOTHER'S MAIDEN NAME <b>Mary Jaeger</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <b>- - - - -</b>			17. INFORMANT <b>Mrs. Carlotta H. Johnston</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b>						INTERVAL BETWEEN ONSET AND DEATH					
334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Diffuse Cerebral Atherosclerosis</b>						3 yrs.					
DUE TO (b) <b>Generalized Atherosclerosis</b>						undetermined					
DUE TO (c) <b>Generalized Atherosclerosis</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 25, 1965</b> , to <b>17 April, 1967</b> , that (I) (we) last saw the deceased alive on <b>17 April 1967</b> , and that death occurred at <b>545 P.M.</b> from causes and on the date stated above											
22a. SIGNATURE <b>Stanley M. Bialek</b>						22b. DATE SIGNED <b>22d. ADDRESS 8218 Wisconsin Ave. Bethesda, Md</b>					
M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								
22c. PHYSICIAN'S NAME (Type) <b>Stanley M. BIALEK</b>						23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4-20-1967</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Rock Creek Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>		
24. FUNERAL DIRECTOR <b>Joseph J. Gavliers</b>						25a. RECEIVED BY REGISTRAR DATE <b>APR 21 1967</b>					
ADDRESS <b>Washington, D.C.</b>						25d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05392

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05390

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1D <i>D.O.A.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Hosp. Carroll Ave</i>		d. STREET ADDRESS <i>7312 15th Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Thomas Finch</i>		First <i>Kingston</i>	Middle <i></i>
4. DATE OF DEATH <i>April 23 1967</i>	Month <i></i>	Day <i></i>	Year <i></i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>10-18-09</i>
9. AGE (In years less birthday) <i>57 yrs.</i>		10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Corp Law</i>	11. BIRTHPLACE (State or foreign country) <i>Georgia</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Wm. Kingston</i>	
14. MOTHER'S MAIDEN NAME <i>Hulda Louise Gilbreath</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No None</i>	
16. SOCIAL SECURITY NO. <i>Yes</i>		17. INFORMANT <i>Dorothy Kingston</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Lobar pneumonia</i>		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John S. Rogers Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <i>4-23-67</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>Apr 24, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Crematory</i>
23d. LOCATION (City, town or county) (State)		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <i>G. Glen Carter, Glen Carter, Warner E. Humphrey, Inc.</i>		25a. ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>	25b. REC'D BY REGISTRAR <i>APR 27 1967</i>
		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05393

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05391

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bedells Island</b>			c. LENGTH OF STAY IN 1b <b>1 week</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Virginia</b>			b. COUNTY <b>Arlington</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac River</b>									c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>					
3. NAME OF DECEASED (Type or print) <b>ROY A. KINNEY</b>			First <b>ROY</b>	Middle <b>A.</b>	Last <b>KINNEY</b>	4. DATE OF DEATH <b>April 1,</b>	Month <b>April</b>	Day <b>1</b>	Year <b>1967</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1940</b>	9. AGE (In years last birthday) <b>26 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Installing Furnaces</b>	11. BIRTHPLACE (State or foreign country) <b>X X X X X War Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>US</b>			

13. FATHER'S NAME <b>Harold Kinney</b>	14. MOTHER'S MAIDEN NAME <b>Priscilla Coleman</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>216-38-1711</b>	17. INFORMANT <b>Margaret E. Kinney-Item # 2</b>	Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> 850X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>Drowning</b>			

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Boat - Swam Pd. and was thrown in River and drowned.</b>	
20c. TIME OF INJURY Month, Day, Year Hour am. 4/11 1967 p.m. 4:30	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>River</b>	20f. (City or town) (County) (State) <b>Bedells Island Mont. Md.</b>

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
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ACTUAL SIGNATURE <i>John G. Boll</i>	EXAMINER'S NAME (Type) <b>John G. Boll</b>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED <b>4/14/67</b>
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	OEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	23. ADDRESS (Street, city, town, or county)	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-16-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>St. Michaels Cemetery Frostburg, Md.</b>	23d. LOCATION (City, town or county) (State) <b>Frostburg, Md.</b>
24. FUNERAL DIRECTOR <b>Joseph R. Durst, Sr.,</b>	ADDRESS <b>Frostburg, Md.</b>	25a. REC'D BY REGISTRAR <b>APR 18 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Cleared by Dr. Hand for Dr. Leape*

CERTIFICATE OF DEATH				05392			
<p><b>1. PLACE OF DEATH</b>            a. COUNTY      <b>Montgomery</b>      MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      <b>Silver Spring</b></p> <p>c. LENGTH OF STAY IN lb      <b>DOA</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  <b>99 Holy Cross Hospital</b></p>				<p><b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b>            a. STATE      <b>Maryland</b>      b. COUNTY      <b>Montgomery</b></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      <b>Rockville</b></p> <p>d. STREET ADDRESS      <b>13906 Marianha Dr.</b></p>			
<p><b>3. NAME OF DECEASED</b>            First      Middle      Last  <b>Rosita</b>      <b>Catherine</b>      <b>Knott</b></p>				<p><b>4. DATE OF DEATH</b>      Month      Day      Year  <b>April</b>      <b>2</b>      <b>1967</b></p>			
<p><b>5. SEX</b>      <b>Female</b></p>		<p><b>6. COLOR OR RACE</b>      <b>White</b></p>		<p><b>7. MARRIED</b>      <input checked="" type="checkbox"/> NEVER MARRIED      <input type="checkbox"/></p> <p><b>WIDOWED</b>      <input type="checkbox"/> <b>DIVORCED</b>      <input type="checkbox"/></p>		<p><b>8. DATE OF BIRTH</b>      <b>1/22/39</b></p> <p><b>9. AGE (In years last birthday)</b>      <b>28</b> yrs.</p>	
<p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)  <b>Housewife</b></p>				<p><b>10b. KIND OF BUSINESS OR INDUSTRY</b></p>			
<p><b>11. BIRTHPLACE</b> (County &amp; State, or foreign country)  <b>Cabaldo, Italy</b></p>				<p><b>12. CITIZEN OF WHAT COUNTRY?</b>      <b>U.S.A.</b></p>			
<p><b>13. FATHER'S NAME</b>  <b>Emilio Yon</b></p>				<p><b>14. MOTHER'S MAIDEN NAME</b>  <b>Armida Yanutolo Yon</b></p>			
<p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b>            (Yes, no, or unknown)      <b>No</b></p>				<p><b>16. SOCIAL SECURITY NO.</b>      <b>Unknown</b></p>			
<p><b>17. INFORMANT</b>      <b>Husband,</b>  <b>Robt. E. Knott</b>      <b>13109 Marianha Dr.</b>      <b>Rkvl., Md.</b></p>				<p>Address</p>			
<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))  <b>PART I. DEATH WAS CAUSED BY:</b></p> <p><b>IMMEDIATE CAUSE (a)</b>      <i>Cardiac Arrest</i></p>				<p><b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>5 mins.</b></p>			
<p><b>443X</b>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  <b>(b)</b>      <i>CONGESTIVE HEART FAILURE</i></p>				<p><b>3 MONTHS</b></p>			
<p><b>(c)</b>      <i>CHRONIC UREMIA</i></p>				<p><b>1 YEAR</b></p>			
<p><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b></p> <p><b>① HYPERTENSION</b>      <b>② NEPHROCALCINOSIS</b></p>				<p><b>19. WAS AUTOPSY PERFORMED?</b>            YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p><b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/>            OR CONTRIBUTING <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)</p>		<p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)</p>					
<p><b>20c. TIME OF INJURY</b> Month, Day, Year            Hour o.m.            p.m.      <b>19</b></p>		<p><b>20d. INJURY OCCURRED</b>            While <input type="checkbox"/> Not While <input type="checkbox"/>            of work <input type="checkbox"/> of work <input type="checkbox"/></p>		<p><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)</p>		<p><b>20f. (City or town)</b>      <b>(County)</b>      <b>(State)</b></p>	
<p><b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>OCTOBER</b>, 19<b>66</b>, <b>to MARCH 2, 1967</b>, that (I) (we) last saw the deceased alive on <b>MARCH 2 1967</b>, and that death occurred at <b>7:00 P.M.</b> from causes and on the date stated above.</p>							
<p><b>22a. SIGNATURE</b>  <i>Dennis J. Hand MD</i></p>				<p><b>22b. DATE SIGNED</b></p>			
<p><b>22c. PHYSICIAN'S NAME (Type)</b>      <b>DENNIS J. HAND</b></p>				<p><b>22d. ADDRESS</b>  <b>10427 Montrose Ave. Bethesda, MD</b></p>			
<p><b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b>  <b>Burial</b></p>		<p><b>23b. DATE THEREOF</b>  <b>4-6-67</b></p>		<p><b>23c. NAME OF CEMETERY OR CREMATORIAL</b>  <b>Gate of Heaven Cem.</b></p>		<p><b>23d. LOCATION (City or Town)</b>      <b>(County)</b>      <b>(State)</b>  <b>Silver Spring, Maryland</b></p>	
<p><b>24. FUNERAL DIRECTOR</b>  <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b></p>				<p><b>ADDRESS</b></p>		<p><b>25a. REC'D BY REGISTRAR</b>  <b>APR 7 1967</b></p>	
<p><b>25b. REGISTRAR'S SIGNATURE</b>  <i>Charles Judge</i></p>							

252

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the hospital or attending physician, page 4 may be retained by the hospital or attending physician. Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

*Medical Examiner notified with approval*

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**05395**

**CERTIFICATE OF DEATH**

**05393**

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>A.C.</i>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tahoma Park</i>		c. LENGTH OF STAY IN 1b <i>14 hrs 20 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		d. STREET ADDRESS <i>45 Nicholson St N.W.</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>WILLIAM S</i>		First	Middle	Last	4. DATE OF DEATH <i>APRIL 4<sup>th</sup> 1967</i>	Month	Day	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/11/1888</i>	9. AGE (In years last birthday) <i>79 yrs.</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. CITIZEN OF WHAT COUNTRY?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Plumber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Plumbing</i>		11. BIRTHPLACE (County & State, or foreign country) <i>D.C.</i>				
13. FATHER'S NAME <i>Unk</i>		14. MOTHER'S MAIDEN NAME <i>Augusta</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <i>Mrs Ethel M Kohler 45 Nicholson St N.W. D.C.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4200</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>ARTERIOSCLEROTIC HEART DISEASE</i> INTERVAL BETWEEN ONSET AND DEATH <i>18 Hrs</i>								
IMMEDIATE CAUSE (a) (b) OUE TO (c) <i>ARTERIOSCLEROSIS</i> 2 yrs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>2 DIABETES MELLITUS</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) ( <i>this hospital</i> ) attended the deceased from <i>1955</i> , 19, to <i>4-4</i> , 19 <i>67</i> , that (I) ( <i>Unk</i> ) last saw the deceased alive on <i>4-3-1967</i> , and that death occurred at <i>5:25 AM</i> , from the causes and on the date stated above.								
22a. SIGNATURE <i>Samuel A. Hillman</i>								
22c. PHYSICIAN'S NAME (Type) <i>SAMUEL A. HILLMAN, M.D.</i>		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4-4-67</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/7/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Prospect Hill Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Washington D.C.</i>		
24. FUNERAL DIRECTOR <i>W.H. Hillman &amp; Son Funeral Home</i>		ADDRESS <i>5732 Georgia Ave</i>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
				DATE <i>APR 7 1967</i>				

02329

02329

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05394

FOR STATE  
HEALTH DEPT.



*to*  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form  
PM3-1 page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of  
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

*Cheneley G. Rogers*

MEDICAL CERTIFICATION

05396		05394				
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAXOMA PARK</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Ft. Geo</i>				
c. LENGTH OF STAY IN lb <i>WASHINGON SAN-Hosp</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>WASHINGON SAN-Hosp</i>		d. STREET ADDRESS <i>3921 Ogletoppe St</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First <i>ARTHUR</i>	Middle <i>CHRISTIAN</i>			
4. DATE OF DEATH <i>APRIL 21</i>		Lost	Month Year 1967			
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>4-17-98</i>		9. AGE (In years lost birthday) <i>69</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MACHINE OPERATOR</i>		11. BIRTHPLACE (State or foreign country) <i>OHIO</i>				
13. FATHER'S NAME <i>EDWARD KRITES</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>297031104</i>				
17. INFORMANT <i>MARY G. KRITES</i>		Address <i>SAME AS #2.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4801</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. <i>Chronic myocardial de-</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs.</i>				
(b) DUE TO <i>Chronic myocardial de-</i>						
(c) <i>lack</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>				
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Bladensburg</i>	(County) <i>Maryland</i>	(State) <i>Maryland</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>John G. Rogers MD</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>4-21-67</i>		
EXAMINER'S NAME (Type) <i>John G. Rogers MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
REMINISTRY PERMIT NO. <i>1897</i>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>APRIL 25, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>FORT LINCOLN</i>		23d. LOCATION (City or Town) <i>BLADENSBURG, MARYLAND</i>
24. FUNERAL DIRECTOR <i>W.W. CHAMBERS Co. RIVERDALE, Md</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>APR 25 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

68380

68380

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05397

## CERTIFICATE OF DEATH

05395

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Rhode Island</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>2 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cranston</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban (FERNAND)</i>		d. STREET ADDRESS <i>97 Copeland St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Paul</i>	Middle <i>Selma</i>	Last <i>Kullberg</i>
4. DATE OF DEATH Month <i>April</i>	Day <i>7</i>	Year <i>1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Jan. 8, 1898</i>	9. AGE (In years last birthday) <i>69 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Machinist</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Providence - Rhode Island</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
13. FATHER'S NAME <i>Frederick Kullberg</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Peterson</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes give war or dates of service) <i>1918</i>	
16. SOCIAL SECURITY NO. <i>037-03-7526A</i>	17. INFORMANT <i>Mr. Charles W. Leake - 7715 Montgomery Ave</i>	Address <i>Elmwood Apartments</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i>	DUE TO <i>584X</i>	INTERVAL BETWEEN ONSET AND DEATH <i>1 DAY</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Peritonitis, localized</i>	DUE TO <i>b</i>	3-4 DAYS	
	DUE TO <i>c</i>	Acute Cholecystitis with Fecal Rupture	3-4 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Aplastic Anemia</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>3/20</i> , 19 <i>67</i> , to <i>present</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4/7</i> , 19 <i>67</i> , and that death occurred at <i>3/20</i> , 19 <i>67</i> , M, fram causes and on the date stated above.			
22a. SIGNATURE <i>John B. Umhoefer</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>4/8/67</i>
22c. PHYSICIAN'S NAME (Type) <i>John B. Umhoefer</i>	22d. ADDRESS <i>8805 Conroy Ave. Cheltenham</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>APR. 11, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Ann's Church Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Cranston Rhode Island</i>
24. FUNERAL DIRECTOR <i>James E. De Vol</i>	ADDRESS <i>2222 Wisconsin NW, DC</i>	25a. REC'D BY REGISTRAR <i>APR 12 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

02300

STATE OF OREGON

02301

1983

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**M**

1  
05398

CERTIFICATE OF DEATH

05396

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN lb <b>18 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JACK ARTHUR LADSON</b>		4. DATE OF DEATH <b>APRIL 5 1967</b>	Doy Year 15 '67
S. SEX <b>MALE</b>	6. COLOR DR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X</b>		B. DATE OF BIRTH <b>12/19/08</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		9. AGE (In years lost birthday) <b>58 yrs.</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>VETERINARIAN</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>THOMAS A. LADSON</b>		14. MOTHER'S MAIDEN NAME <b>JESSIE DAVIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215 36 4096</b>	
17. INFORMANT <b>MEDICAL RECORDS</b>		Address	
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Biliary Obstruction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>18</b>
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 2:45PM, from causes and on the date stated above.		(City or town) (County) (State)	
22a. SIGNATURE <b>C. H. LIGON, M.D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4/15/67</b>
22c. PHYSICIAN'S NAME (Type) <b>C. H. LIGON, M.D.</b>		22d. ADDRESS <b>SANDY SPRING MEDICAL CENTER, TOWSON, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 8 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Parklawn Laytonsville Md.</b>
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>		23d. LOCATION (City or Town) <b>Rockville</b>	
		(County) (State) <b>Montgomery Co. Md.</b>	
		25a. REGISTRY REGISTRATION DATE <b>APR 18 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Minneapolis Judge</b>

Year availability

minimum 3000 ft²

for

any purpose

above efficiency

located in Brazil

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b				b. COUNTY <b>Montgomery</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5608 Pollard Road,</b>								c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (D.C. 20016)</b>							
				d. STREET ADDRESS <b>5608 Pollard Road,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Frances</b>	Middle <b>M.</b>	Last <b>Lane</b>	4. DATE OF DEATH <b>April 20, 1967</b>	Month <b>April</b>	Day <b>20</b>	Year <b>1967</b>							
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 27, 1915</b>	9. AGE (In years last birthday) <b>51</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>									
13. FATHER'S NAME <b>John Pawling</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Dowling</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Edward F. Lane, 5608 Pollard Rd.</b>		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1750</b>												<i>Cardiac arrest</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)												<i>metastatic Carcinoma ovary</i>			
DUE TO (c)												<i>Carcinoma ovary</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. p. m.		Month <b>July</b>	Day <b>19</b>	Year <b>1967</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Anad 20, 1967</b>		(County) <b>Wheaton</b>		(State) <b>Maryland</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 1967, to <b>Anad 20, 1967</b> , that (I) (we) last saw the deceased alive on <b>Anad 20, 1967</b> , and that death occurred at <b>11P.M.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>J. E. Fitzgerald</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE <b>APR 28 1967</b>							
22c. PHYSICIAN'S NAME (Type) <b>J. E. Fitzgerald</b>				22d. ADDRESS <b>Washington, DC</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 24, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Gate of Heaven Cem.</b>		23d. LOCATION (City, town, or county) <b>Wheaton, Maryland</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Don, DeVol</b>		ADDRESS <b>2222 Wis. Ave. N.W.</b>		25a. REC'D BY REGISTRAR <b>APR 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>DeVol Judge</b>									
				DATE <b>APR 28 1967</b>											

10000

10000 STATE OF CALIFORNIA  
10000 NO STANDING

10000

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05400		05398	
1. PLACE OF DEATH a. COUNTY <i>Montgomery - Wheaton</i>		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		c. LENGTH OF STAY IN 1b <i>25 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Randolph Hills Nursing Home</i>			
3. NAME OF DECEASED (Type or print)	First <i>MARY</i>	Middle <i>ELIZABETH</i>	Last <i>Lanehart</i>
4. DATE OF DEATH	Month <i>January</i>	Day <i>8</i>	Year <i>1967</i>
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>11/23/1895</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales Clerk</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Dept. Store</i>	11. BIRTHPLACE (County & State, or foreign country) <i>D.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>Natural</i>
13. FATHER'S NAME <i>John Garrett Prenddile</i>	14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Gettner</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <i>578 12 2144A</i>	17. INFORMANT <i>Nursing Home Records</i>	Address <i>Aging Record</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of pancreas</i> 157X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized arteriosclerosis.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 11</i> , 1963 to <i>Jan 5, 1967</i> , that (I) (we) last saw the deceased alive on <i>Aug 5, 1967</i> , and that death occurred at <i>home</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>C.P. Ryland</i>	22b. DATE SIGNED <i>4-8-67</i>		
22c. PHYSICIAN'S NAME (Type) <i>4400-49 87 NW</i>	22d. ADDRESS <i>C.P. RYLAND</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE THEREOF <i>April 12, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Nat'l Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Arlington, Va.</i>
24. FUNERAL DIRECTOR <i>J. Hines Co. 2901 14st. N.W.</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>APR 12 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

80620

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05401

CERTIFICATE OF DEATH

05399

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>			c. LENGTH OF STAY IN lb		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring</b>			d. STREET ADDRESS <b>11811 Brooke Rd.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Clara Lyman Latham</b>			4. DATE OF DEATH Month <b>11 23 1967</b>	Month Year <b>1967</b>	Doy Year
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-28-79</b>	9. AGE (In years lost birthday) <b>87 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <b>Unemployed</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	12. CITIZEN OF WHAT COUNTRY? <b>US</b>
13. FATHER'S NAME <b>Amos Richardson</b>			14. MOTHER'S MAIDEN NAME <b>Cornelius</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.      17. INFORMANT      Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TERMINAL RENAL SHUTDOWN - URETHRA</b> *INTERVAL BETWEEN DEATH AND DEATH 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO <b>ARTERIOULAR NEPHROSCLEROSIS</b> YES. <b>GENERALIZED ARTERIOSCLEROSIS</b> YES.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>RHODERMA GANGRENOSUM, CREST WALL - ARTHRITIS - STROKES</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m.      p.m.      19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>SEPT</b> , 19 <b>66</b> to <b>23 APR</b> , 19 <b>67</b> , that (we) just saw the deceased alive on <b>33 APR 1967</b> , and that death occurred at <b>212 M</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Donald R. Lewis</b>			22b. DATE SIGNED <b>23 April 67</b>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/27/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Eulalia Cem. Pa.</b>		23d. LOCATION (City or Town) (County) (State) <b>Couderport, Pa.</b>
24. FUNERAL DIRECTOR <b>Robert C. Morden</b>		ADDRESS <b>Rockville</b>	25a. REC'D BY REGISTRAR DATE <b>APR 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Wendell J. Inden</b>

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05402

## CERTIFICATE OF DEATH

05400

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Virginia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>11 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		e. STREET ADDRESS <b>302 East 27th Street</b>	
3. NAME OF DECEASED (Type or print) <b>Mildred</b>		First <b>Pearl</b>	Middle <b>Lathan</b>
4. DATE OF DEATH Month <b>April</b>	Month <b>10</b>	Doy <b>1967</b>	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>26 June 1907</b>	9. AGE (In years lost birthday) <b>59 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Henry Crosling</b>		14. MOTHER'S MAIDEN NAME <b>Martha (Unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>The Medical Records, Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Tubular Necrosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 Mo.</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>171X</b>			
(b) <b>Radiation Recurrent Cancer of the Cervix</b>		2 Yrs.	
DUE TO Disease			
(c) <b>Hypertensive &amp; Arteriosclerotic Cardiovascular/</b>		10 Yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Diabetes</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town) (County) (State)</b>
21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>March 30, 1967</b> , to <b>April 10, 1967</b> , that <b>XX</b> (we) last saw the deceased alive on <b>April 10, 1967</b> , and that death occurred at <b>2:49 PM</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>April 14, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frank C. Sparks, M. D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>	
23d. BURIAL, CREMATION, REMOVAL (Specify) <b>\$11/67</b>	23b. DATE THEREOF <b>4/11/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Harmony Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>Lanham, Maryland</b>
24. FUNERAL DIRECTOR <b>Frazier's Funeral Home, Inc.</b>		ADDRESS <b>389 R.I.Ave. NW</b>	25a. REC'D BY REGISTRAR <b>APR 19 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

00120

NAME OF SUBJECT

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>													
M 05403						05401							
<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>						<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>							
<b>c. LENGTH OF STAY IN lb</b> <del>4 1/2 hrs</del>						<b>d. STREET ADDRESS</b> <del>5101 Ridgefield Road</del>							
<b>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</b> <del>Suburban Hospital</del>						<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>Fannie MABEL Laut</b>		First	Middle	Last		DATE OF DEATH	Month	Day	Year				
S. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.				
Female	white					Aug. 9, 1894	72 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?				
<del>Housewife</del>			<del>--</del>			<del>Quincy - Mass.</del>			<del>USA</del>				
<b>13. FATHER'S NAME</b> <del>Vincent M. Grusler</del>													
<b>14. MOTHER'S MAIDEN NAME</b> <del>Nellie Peterson</del>													
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <del>yes - Navy-W.W.I</del>				<b>16. SOCIAL SECURITY NO.</b> <del>220-50-5573</del>				<b>17. INFORMANT</b> <del>John A. Laut - husband</del>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <del>Hemorrhage Massive rt Cerebrum</del> <del>33IX</del> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <del>Cerebral Arteriosclerosis</del> <b>(b)</b> DUE TO <b>(c)</b>													
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)</b>													
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Name, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <del>Rockville</del>		<b>(County)</b> <del>Md.</del>		<b>(State)</b> <del>MD</del>	
<b>21. I certify that (I) (this hospital) attended the deceased from <del>March</del>, 1967, to <del>April 26, 1967</del>, that (I) (we) last saw the deceased alive on <del>April 26, 1967</del>, and that death occurred at <del>11:45 PM</del>, from causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <del>Michael J. Trealy</del>						<b>22b. DATE SIGNED</b> <del>4/26/67</del>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <del>Michael J. Trealy</del>						<b>22d. ADDRESS</b>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <del>Burial</del>		<b>23b. DATE THEREOF</b> <del>5-1-1967</del>		<b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <del>Parklawn Cemetery</del>		<b>23d. LOCATION (City or Town)</b> <del>Rockville, Md.</del>		<b>(County)</b> <del>Md.</del>		<b>(State)</b> <del>MD</del>			
<b>24. FUNERAL DIRECTOR</b> <del>Joseph Gawler's Sons, Inc.</del> <del>5130 Wisconsin Ave., N.W. Wash. DC.</del>						<b>ADDRESS</b>							
						<b>25a. REC'D. BY REGISTRAR</b> <del>MAY 2</del>		<b>25b. REGISTRAR'S SIGNATURE</b> <del>Charles Judge</del>					

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05404

**CERTIFICATE OF DEATH**

05402

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Tennessee</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>27 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Herman</b>		First <b>William</b>	Middle <b>Lawson</b>
4. DATE OF DEATH <b>April 29 1967</b>	Month <b>April</b>	Doy <b>29</b>	Year <b>1967</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 13, 1928</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		9. AGE (In years last birthday) yrs. <b>38</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Publishing Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Tennessee</b>	
13. FATHER'S NAME <b>James R. Lawson</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>409-38-8724</b>	17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Md. 20014</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple pulmonary emboli</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 Weeks</b>			
416 X DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) <b>Sagittal sinus thrombosis</b> terminal stating the underlying cause (last) DUE TO (c) <b>Rheumatic heart disease</b> 28 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Thrombosis of periprostatic and deep femoral veins, right - 2 weeks</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour: a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 2 1967</b> , to <b>April 29 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 29 1967</b> , and that death occurred at <b>9:05 M</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Robert Zelis</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>29 April 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>Robert Zelis, MD</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 2, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Jarnagin Cemetery</b>
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>		ADDRESS <b>BETHESDA, MARYLAND</b>	25a. REC'D BY REGISTRAR <b>MAY 3 1967</b>
ROBERT A. PUMPHREY			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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DISCRETE / INDIVIDUAL / ELEMENTS RELATED TO F.D. VOL.



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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05406

## CERTIFICATE OF DEATH

05404

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. LENGTH OF STAY IN lb <b>18 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Randolph Hills Nursing Home</b>		d. STREET ADDRESS <b>8401 16th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>John</b>	Middle <b>Edmund</b>	Last <b>Leathem</b>	4. DATE OF DEATH Month <b>April</b>	Month <b>18</b>	Doy <b>19</b>	Year <b>67</b>
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr 27, 1882</b>	9. AGE (In years last birthday) <b>84 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. DAYS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Brooklyn, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard W. Leathem</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Finnegan</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Grace S. Leathem</b>		Address <b>8401 16th Street Silver Spring, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <b>Pylemon ephritis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Generalized arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/25</b> , 19 <b>67</b> to <b>4/18</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4/18</b> 19 <b>67</b> , and that death occurred at <b>440</b> M, fram causes and an the date stated above.							
22o. SIGNATURE <b>Raymond T. Benack</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Raymond T. Benack MD</b>		22d. ADDRESS <b>4115 Colie Dr. Wheaton, Md.</b>					
23o. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Apr 19, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Glen Carter</b>		ADDRESS <b>8434 Georgia Avenue Warren E. Pumphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>APR 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE M  
HEALTH DEPT

05407

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05405

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i> <i>Bethesda</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> <i>Fairfax</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>2 1/2 days.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Sugarland Hospital</i>		d. STREET ADDRESS <i># 1 Box 49 1/2</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Marietta Jones</i>		First <i>Jee</i>	4. DATE OF DEATH Month <i>April</i> Day <i>28</i> Year <i>1967</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/no, or unknown)		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Edward Hebrew</i>		14. MOTHER'S MAIDEN NAME <i>Henrietta Johnson</i>	
15. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho Pneumonia</i> DUE TO <i>8254</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Intra Cranial Hemorrhage</i> DUE TO <i>Auto Accident</i> (c) <i>Auto Accident</i> DUE TO <i>9 1/2 weeks</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>9 Weeks</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>in Auto accident - bump - head causing hemorrhage -</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>1:30 a.m. 2/21 1967</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <i>at work</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Street -</i>
20f. (City or town). (County) (State) <i>Sugarland - Mint - Md.</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <i>4/18/67</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>5/2/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Sugarland Cem.</i>
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i>		25a. LOCATION (City or Town) (County) (State) <i>Sugarland Monty Md.</i>	
		25b. REC'D BY REGISTRAR <i>D MAY 2 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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W. H. C. - 1900  
W. H. C. - 1900

subacute process with respect to the world's health.

$$\ln x + \frac{1}{2}M - \mu = 0 \Rightarrow x = e^{-\frac{1}{2}M + \mu}$$

13/20

Jan 2008

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4** may be retained by the hospital or attending physician.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
<i>Montgomery Co., Maryland</i>		a. STATE <i>Maryland</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>24 hrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Silver Spring</i>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print)	First <i>Ernest</i>	Middle <i>F.</i>	Last <i>Lehmann</i>
4. SEX <input checked="" type="checkbox"/> Male	5. COLOR OR RACE <input checked="" type="checkbox"/> white	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	7. DATE OF BIRTH <i>9/30/77</i>
8. AGE (In years last birthday) <i>89 yrs.</i>	9. IF UNDER 1 YEAR IF UNDER 24 HRS. <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>INTERIOR DECORATOR</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>same</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>NEBRASKA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Augusta Henry Lehmann</i>		14. MOTHER'S MAIDEN NAME <i>Augusta</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. <i>507-01-40491</i>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>70 days</i>	
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arterosclerotic Heart disease.</i>		DUE TO <i>St yes.</i>	
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>p.m.</i> 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <i>1 Jan 1967</i> to <i>21 April 1967</i> , that (I) (we) last saw the deceased alive on <i>20 April 1967</i> , and that death occurred at <i>3 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>A.H. Richwine</i>		22b. DATE SIGNED <i>21 April 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>A.H. RICHWINE, MD.</i>		22d. ADDRESS <i>22 WESTERN PL</i> <i>CHERRY CREEK, MD.</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>Apr. 22, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>3rd Lincoln Crematory</i>		23d. LOCATION (City, town or county) <i>Pt. Geo. Co. Maryland</i>	
24. FUNERAL DIRECTOR <i>Arthur Walters, 254 Carroll NW DC</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>DATE APR 24 1967</i>	

up to  
and to the  
southern boundary

to the north of  
H. H. Bickel, MD  
several cattle  
which were  
seen to be  
in the pasture

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>				05407			
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN lb. <b>18 months</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2945 TERRACE Drive</b>				<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>2945 TERRACE Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> <small>(Type or print)</small> <b>FANNIE PALACE</b> <small>First Middle Last</small> <b>LEVINSON</b>		<b>4. DATE OF DEATH</b> <small>Month Day Year</small> <b>April 22 1967</b>					
<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <small>WIDOWED</small> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>April 15, 1909</b> <b>9. AGE (In years lost birthday)</b> <b>58 yrs.</b>	<small>IF UNDER 1 YEAR</small> <small>Months Days Hours Min.</small>				
<b>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Housewife.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-</b>	<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <b>Russia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>AMERICA</b>		
<b>13. FATHER'S NAME</b> <b>ARON Palace</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>TILLEY Rocklin</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> <small>(Yes, no, or unknown)</small> <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>578-64-6444</b>		<b>17. INFORMANT</b> <b>IRVIN Levinson - 2945 TERRACE Dr</b> <small>Address</small> <b>CHEVY, CHASE</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <small>PART I. DEATH WAS CAUSED BY:</small> <small>IMMEDIATE CAUSE (a)</small> <b>3561</b> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</small> <small>(b)</small> <b>Respiratory Failure</b> <small>due to</small> <small>(c)</small> <b>Amyotrophic Lateral Sclerosis</b> <small>due to</small> <small>(d)</small> <b>Chronic Bronchitis</b> <small>due to</small>				<small>INTERVAL BETWEEN ONSET AND DEATH</small> <small>12 HOURS</small> <small>2 years.</small>			
<b>19. WAS AUTOPSY PERFORMED?</b> <small>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></small>							
<b>20. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <small>OR CONTRIBUTING</small> <input type="checkbox"/> <b>CAUSE OF DEATH</b> <small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <small>20c. TIME OF INJURY</small> Month, Day, Year <small>Hour o.m.</small> <b>October 1967</b> <small>p.m.</small> <b>19</b>			
				<b>20d. INJURY OCCURRED</b> <small>While at work</small> <input type="checkbox"/> <small>Not While at work</small> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <small>20f. (City or town)</small> <b>Bethesda</b> <small>(County)</small> <b>Md.</b> <small>(State)</small> <b>Md.</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>October 1967</b> , to <b>April 22, 1967</b> , that (I) ( ) last saw the deceased alive on <b>April 22 1967</b> , and that death occurred at <b>4:10p M</b> , from causes and on the date stated above.							
<b>22o. SIGNATURE</b> <b>Jack Crowell MD</b>				<b>22b. DATE SIGNED</b> <b>April 22, 1967</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>JACK CROWELL MD</b>				<b>22d. ADDRESS</b> <b>2025 Eye St. N.W. Washington, DC</b>			
<b>23o. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4/24/67</b>		<b>23c. NAME OF CEMETERY OR CREMATORIAL</b> <b>Beth Israel Death Chapel</b>		<b>23d. LOCATION (City or Town)</b> <b>Bethesda</b> <small>(County)</small> <b>Md.</b> <small>(State)</small> <b>Md.</b>	
<b>24. FUNERAL DIRECTOR</b> <small>ADDRESS</small> <b>Sylvan S. Levinson, Inc Garrison, Md</b>				<b>25o. RECD BY REGISTRAR</b> <small>DATE</small> <b>APR 25 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**M** 1  
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH										
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
o. COUNTY Montgomery MARYLAND					o. STATE Virginia					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					c. LENGTH OF STAY IN 1b 29 Days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED First Donnie Middle Mae Lewis					4. DATE OF DEATH April 5 1967					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 April 1909		9. AGE (In years lost birthday) 57 yrs.		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					11. BIRTHPLACE (County & State, or foreign country) Georgia					
13. FATHER'S NAME John W. Cannon					14. MOTHER'S MAIDEN NAME Mattie Belle Hardrick					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. ---					
17. INFORMANT The Medical Records Address Not Available					18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Intraperitoneal hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <u>Peritonitis</u> DUE TO (c) <u>Radiation recurrent carcinoma of cervix</u>					
					INTERVAL BETWEEN ONSET AND DEATH 36 hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>Frank C. Sparks, MD</u> attended the deceased from <u>7 March</u> , 1967, to <u>5 April</u> , 1967, that <u>he</u> (we) last saw the deceased alive on <u>5 April</u> , 1967, and that death occurred on <u>11:00 M</u> , from causes and on the date stated above.					22b. DATE SIGNED <u>6 April 1967</u>					
22a. SIGNATURE <u>Frank C. Sparks, M.D.</u>					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/8/67</u>					23b. DATE THEREOF <u>4/8/67</u>		23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City or Town) (County) (State) <u>Nex Norfolk, Va.</u>	
24. FUNERAL DIRECTOR <u>Frazier's Funeral Home, Inc.</u> 309 Rhode Island Ave., N.W. Wash., D.C.					ADDRESS		25a. REC'D BY REGISTRAR DATE <u>APR 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Alvante's Judge</u>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 2 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
05411				05409							
1. PLACE OF DEATH <b>Montgomery County</b> <b>Kensington</b> , MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 473			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kensington Nursing Home</b>				d. STREET ADDRESS <b>1510 VARNUM St. N.W.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary MAMIE</b>				First	Middle	Last	4. DATE OF DEATH <b>April 5 1967</b>				
5. SEX <b>F</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-20-1869</b>		9. AGE (In years at birthday) <b>97</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Georgia</b>			
13. FATHER'S NAME <b>John L. Burkhalter</b>				14. MOTHER'S MAIDEN NAME <b>Virginia - Burkhalter</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Home Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myocardial Insufficiency</b> (c) <b>Arteriosclerotic Heart Disease.</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Washington</b> (County) <b>D.C.</b> (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D. Washington, D.C.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4/8/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Rock Creek Cemetery</b>				23d. LOCATION (City or Town) <b>Washington, D.C.</b> (County) <b>D.C.</b> (State)			
24. FUNERAL DIRECTOR <b>The S.H. Hines Company</b> 2901 14th St. N.W. Washington, D.C.								25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Charles Judd</b> DATE <b>APR 10 1967</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

**05412** Item#8F1m#G3871/ 12/67 PC

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>MINUTES</b>		b. COUNTY <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSP.</b>		d. STREET ADDRESS <b>8023 PINEY BRANCH RD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>SERECK</b>	Middle <b>EELWOOD</b>	Last <b>LIVEZEY</b>	4. DATE OF DEATH <b>4/6</b>	Month Day Year <b>1967</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-18-1840</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLUMBER CONT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PLUMBING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>HARTFORD Co., Maryland</b>	
13. FATHER'S NAME <b>JACOB LIVEZEY</b>		14. MOTHER'S MAIDEN NAME <b>ROBERTS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Nora A. Livesey</b>	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART Disease</b>					
260X DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>DIABETES MELLITUS</b>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>10400 Conn. Ave KENS, md</b>	
20f. (City or town) <b>(County)</b> <b>(State)</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>JANUARY</b> , 19 <b>67</b> , to <b>4/6</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4/6</b> , 19 <b>67</b> , and that death occurred at <b>3 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Richard H. Pollen</b>					
22b. DATE SIGNED <b>4/6/67</b>					
22c. PHYSICIAN'S NAME (Type) <b>Richard H. Pollen</b>		22d. ADDRESS <b>10400 Conn. Ave KENS, md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 10, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Zion Cemetery</b>	
24. FUNERAL DIRECTOR <b>Robert Walters</b>		ADDRESS <b>Takoma Park Funeral</b>		23d. LOCATION (City, town or county) <b>Fountain Green, Md.</b>	
25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		(State)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

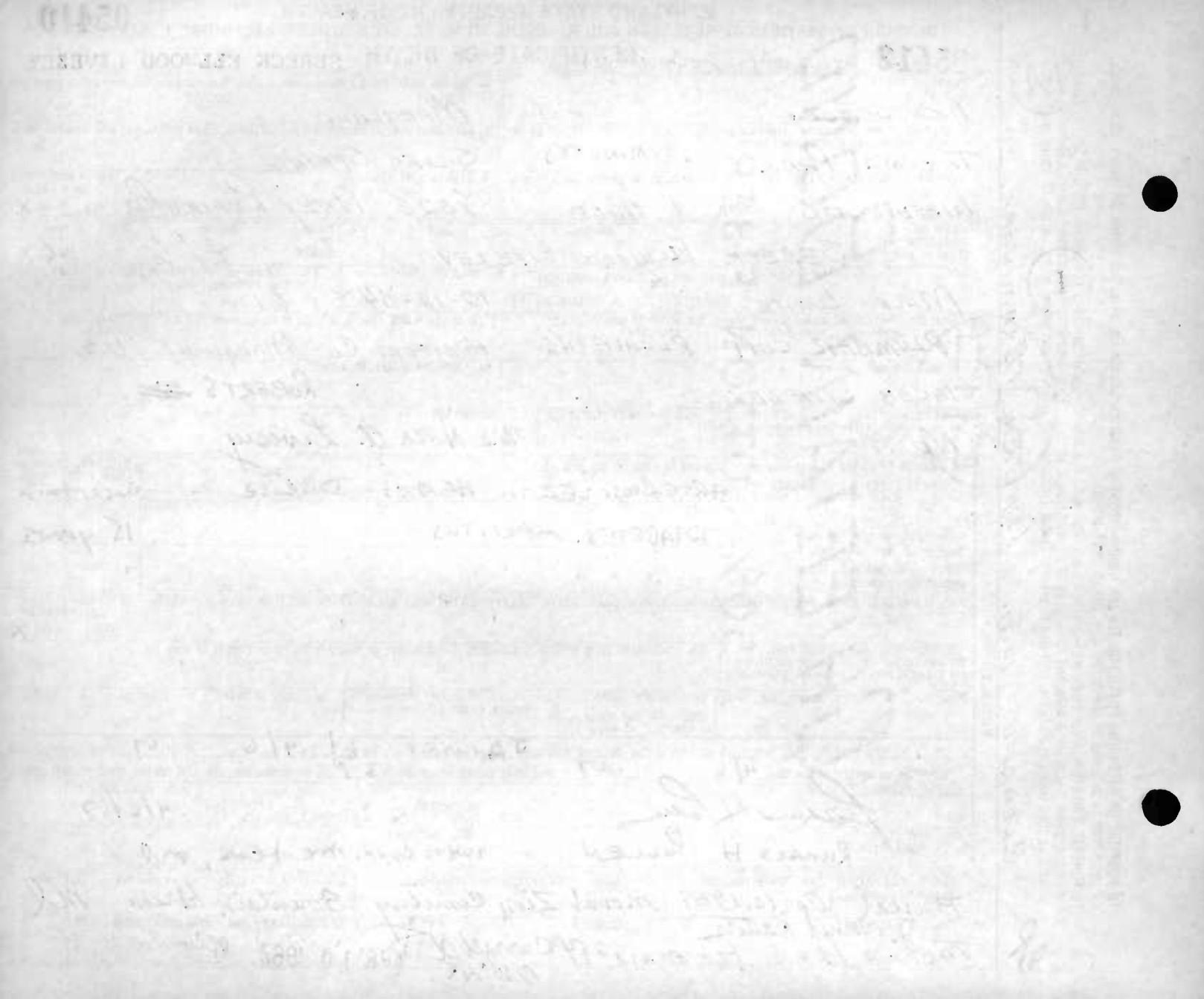
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Medical Examiner*

*Cleared with*

VR A15 (4)  
20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

05413

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05411

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY <b>Montgomery</b> MARYLAND		b. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase - 3 miles NW</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase -</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3535 Chevy Chase Lake Dr.</b>		d. STREET ADDRESS <b>3535 Chevy Chase Lake Dr.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First <b>Katherine</b> Middle <b>Davis</b> Last <b>Locke</b>		4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>1967</b>	
5. SEX <b>Fe-</b>		6. COLOR OR RACE <b>W-</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 22, 1939</b>	
WIDOWED <input type="checkbox"/>		9. AGE (In years lost birthday) <b>27 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Research Assistant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethesda Naval Hosp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George David Davis</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Maynard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>153-28-2106</b>	
17. INFORMANT <b>Edwin A. Locke</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: <b>976X</b> IMMEDIATE CAUSE (a) <b>Gun Shot Wound. of Head.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
DUE TO (b) <b>Self-inflicted..</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>{</b>		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: <b>X</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in head with 32 cal. Pistol</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>9</b> p.m. <b>4/9</b> 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>House</b>		20f. (City or town) (County) (State) <b>Chevy Chase Mont. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John G. Ball</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>Bethesda, Md</b>	
22. DATE SIGNED <b>4/11/67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Apr 12, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Lincoln Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Glen Carter</b>		25a. ADDRESS <b>8434 Georgia Avenue</b>	
Warner E. Pumphrey, Inc.		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	
6M 1/67		25c. REC'D BY REGISTRAR <b>APR 17 1967</b>	

1140

CH

problem - difficulty  
of individual species

of individual species  
and their adaptability

to new soil and climate  
and their adaptability

to new soil and climate  
and their adaptability

1125

problem - difficulty  
of individual species

of individual species  
and their adaptability

problem - difficulty  
of individual species

adaptability

adaptability

adaptability

adaptability

adaptability

adaptability

adaptability

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH		05412	
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CHEVY CHASE NURSING AND Convalescent Center</u>		e. STREET ADDRESS <u>8600 16<sup>th</sup> ST.</u> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PAULINE</u> First <u></u> Middle <u>Loketoff</u> 6. SEX <u>Female</u> 7. COLOR OR RACE <u>CAU</u>		4. DATE OF DEATH <u>APRIL 10, 1967</u> Month <u>MARCH</u> Day <u>10</u> Year <u>1967</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACK PREISON STOCK</u>		14. MOTHER'S MAIDEN NAME <u>FANNY YOUNG</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>MAXINE SHERER</u> Address <u>8600 16<sup>th</sup> St., Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of cerebral artery</u> DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) <u></u> stating the underlying cause <u></u> last. <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>14R.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that <u>(I)</u> (this hospital) attended the deceased from <u>June 5, 1967</u> to <u>4-10-1967</u> that <u>(I)</u> (we) last saw the deceased alive on <u>4-10-1967</u> , and that death occurred at <u>10pm</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Max G. Sherer</u> M.D.		22b. DATE SIGNED <u>4-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MAX G. SHERER MD</u>		22d. ADDRESS <u>800 Pershing Dr. Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-12-67</u>	
23c. NAME OF CEMETERY OR CREMATORIAL <u>Adas Israel Cem.</u>		23d. LOCATION (City or Town) <u>Washington</u> (County) <u>D.C.</u> (State) <u></u>	
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home 4217 1/2 St. NW</u>		ADDRESS 25a. REC'D. BY REGISTRAR DATE <u>APR 12 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

S120

HAGG 77-3147-003

A120

Wetzel

South Laramie River

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Water no further on 5M 33E 2 - 100

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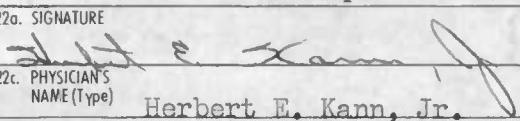
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05415

CERTIFICATE OF DEATH

05413

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>87 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>		d. STREET ADDRESS <b>57-R Ridge Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>							
3. NAME OF DECEASED (Type or print)		First <b>Keith</b>	Middle <b>Andreas</b>	Last <b>Longas</b>	4. DATE OF DEATH <b>April 27 1967</b>	Month Day Year	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8 June 1960</b>	9. AGE (In years lost birthday) <b>6 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Socrates A. Longas</b>				14. MOTHER'S MAIDEN NAME <b>Leona Blackman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure, Refractory</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Suspected Drug Toxicity</b> <b>2 Wks.</b> DUE TO (c) <b>Acute Lymphocytic Leukemia</b> <b>3½ Yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 30, 1967</b> , to <b>April 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>27 April 1967</b> , and that death occurred at <b>7:05 M</b> , from causes and on the date stated above.							
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input type="checkbox"/>		P.M. MED. DIRECTOR <input type="checkbox"/>		22b. DATE SIGNED <b>28 April 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Herbert E. Kann, Jr.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4/30/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Chesed Shel Emmes</b>		23d. LOCATION (City or Town) (County) (State) <b>Hillside, Maryland</b>	
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons St., N.W. Wash.</b>		ADDRESS <b>3501-14th</b>		25a. REC'D BY REGISTRAR <b>CMAY 2</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

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HEAD - DIAFRAGM

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05416

## CERTIFICATE OF DEATH

This

05414

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. John Rogers (Medical Examiner) Notified &amp; Certified

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		
c. LENGTH OF STAY IN 1b <i>DoA</i>		d. STREET ADDRESS <i>9708 Montebello ave</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>99 Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>JOHN ELDRIDGE LOVELESS</i>		First <i>J</i>	Middle <i>E</i>	
4. DATE OF DEATH <i>Feb 11, 1967</i>		Last <i>19</i>	Month <i>Feb</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 11, 1895</i>	
9. AGE (In years last birthday) <i>72 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Interior Decorator</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Washington, DC</i>	12. CITIZEN OF WHAT COUNTRY? <i>yes</i>	
13. FATHER'S NAME <i>Warren R Loveless</i>	14. MOTHER'S MAIDEN NAME <i>Carrie E Jones</i>	Address <i>Same as Item 2.</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes.</i>	16. SOCIAL SECURITY NO. <i>WW I 578-03-4015</i>	17. INFORMANT <i>Wife</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Coronary Heart Disease</i> DUE TO DUE TO (b) <i>Coronary Heart Disease</i> (c)	INTERVAL BETWEEN ONSET AND DEATH <i>suicide</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>p.m.</i> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Rockville</i> (County) <i>Montgomery</i> (State) <i>Md</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>4-19</i> , 19 <i>67</i> , to <i>4-19</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Dec 19</i> , and that death occurred at <i>12:55 PM</i> , from causes and on the date stated above.				
22a. SIGNATURE <i>J. Marion Bankhead</i>	22b. DATE SIGNED <i>4/19/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>J. Marion Bankhead</i>	22d. ADDRESS <i>1505 Dale Dr Silver Spring, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>4-21-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cemetery</i>	23d. LOCATION (City or Town) <i>Washington, D. C.</i> (County) <i>D. C.</i> (State)	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>APR 24 1967</i>				

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PIECE

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05417

CERTIFICATE OF DEATH

05415

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages **1** and **2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event,

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kenwood</b>		c. LENGTH OF STAY IN lb <b>16 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kenwood</b>		d. STREET ADDRESS <b>5316 Oakland Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5316 Oakland Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anthony Fitzgerald Lucas</b>		4. DATE OF DEATH Month <b>April</b> Month <b>6</b> ,      Day <b>1967</b>	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH <b>7-21-1889</b>
9. AGE (In years last birthday) <b>77</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Engineer</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Anthony F. Lucas</b>	14. MOTHER'S MAIDEN NAME <b>Caroline Fitzgerald</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>1919-1919</b>	
16. SOCIAL SECURITY NO. <b>577-36-8292-A</b>	17. INFORMANT <b>Ruth H. Lucas, See Item No. 2.</b>	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of prostate gland</b> DUE TO <b>177X</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>arteriosclerotic cardiac disease</b>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1801 K St. N.W. Washington, D.C.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>February 1, 1967</b> , to <b>April 26, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 29, 1967</b> , and that death occurred at <b>2 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Alban W. Eger</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR	22b. DATE SIGNED <b>Apr 26, 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>Alban W. Eger</b>		22d. ADDRESS <b>1801 K St. N.W. Washington, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-8-1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rock Creek Cemetery</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc. Wash, D.C.</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>APR 11 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

112

17  
1 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05418 CERTIFICATE OF DEATH 05416

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remit carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>1707 Cody Drive</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sanitarium</b> <b>Washington Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Dr. John Henry MacDermott</b>		First	Middle	Lost	4. DATE OF DEATH <b>1-27-</b>	Month	Doy	Year	
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-11-87</b>	9. AGE (In years lost birthday) <b>79 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dental Surgeon</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dentistry</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. America</b>			
13. FATHER'S NAME <b>John T. MacDermott</b>				14. MOTHER'S MAIDEN NAME <b>Katherine MacGurk</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>H.H. 1 army 278-38-6183</b>		17. INFORMANT <b>Helen B. Mac Dermott</b>		Address <b>1707 Cody Drive Silver Spring, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b>		DUE TO <b>Congestive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO <b>Massive Myocardial Infarction, old.</b>		(c) DUE TO <b>Coronary Atherosclerosis</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anemia - secondary to nasal hemangioma</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 18, 1967</b> , to <b>April 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 26, 1967</b> , and that death occurred at <b>1707</b> M, from causes and on the date stated above.									
22a. SIGNATURE <b>Philip E. Jones</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <b>Philip E. Jones</b>		22d. ADDRESS <b>800 Pershing Drive Silver Spring, Md.</b>		22e. DATE SIGNED <b>4/27/67</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-1-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Parklawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>			
24. FUNERAL DIRECTOR <b>Glen Carter Cremants, 8434 Georgia Avenue Warren E. Pumphrey, Inc.</b>		ADDRESS <b>Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE			
				DATE <b>MAY 1 1967</b>					

92126

1950-30-349723

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05413

CERTIFICATE OF DEATH

05417

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>40 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jakoma Park</i>		d. STREET ADDRESS <i>8110 Hammond Ave.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Margaret E. Mackin</i>	First <i>E.</i>	Middle <i></i>	Last <i></i>
4. DATE OF DEATH <i>April 30 1967</i>	Month	Doy	Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/3/1886</i>
9. AGE (In years last birthday) <i>80 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homeemaker</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Willowdale, Ga</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John Mc Crea</i>	14. MOTHER'S MAIDEN NAME <i>SUSAN JANE Crookham</i>	Address <i>Same as above</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT	
		<i>Daughter, Mrs Helen M. Brown</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA OF COLON</i>			
1538 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Colmar Manor</i>		(County) <i>MD</i>	
		(State) <i>MD</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>1/15</i> , 19 <i>60</i> , to <i>4/30</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4/29</i> 19 <i>67</i> , and that death occurred at <i>1:10 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>John E. Everett</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>John E. EVERETT</i>		22d. DATE SIGNED <i>Apr. 30. 1967</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 3, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City or Town) <i>Colmar Manor</i>	
		(County) <i>MD</i>	
24. FUNERAL DIRECTOR <i>John E. Everett</i>		25a. ADDRESS <i>1445 N.W. 254 Carroll St N.W.</i>	
		25b. REGD BY REGISTRAR <i>MAY 2 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Justice</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STAFF  
HEALTH DEPT.

05420

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05418

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>10 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2315 Blue Ridge Ave. apt. 15</u>		e. STREET ADDRESS <u>2315 Blue Ridge Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Maybelle Freeman Meddix</u>		First <u>Touart</u> Middle <u>Frederick</u> Last <u>Meddix</u>	4. DATE OF DEATH <u>APRIL 13 1967</u>
5. SEX <u>F</u> .	6. COLOR OR RACE <u>W</u> .	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 Sept 1896</u> 9. AGE (In years last birthday) <u>70 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Resident Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Apt. House</u>	11. BIRTHPLACE (State or foreign country) <u>Mobile, Alabama</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>273-1612234</u>	17. INFORMANT <u>Mrs. Ellen L. Sherwood</u> Address <u>Silver Spring, Md.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage Massive.</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis Severe.</u> DUE TO <u>Years.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u> sudden.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> Not at work <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>807 Lanarkway</u> (County) <u>Baltimore</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	John G. Ball M.D. 7936 Old Georgetown Rd. John G. Ball, M.D. Bethesda, Md.		
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Date <u>4/14/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>18 Apr 1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Arlington National Cem.</u>
23d. LOCATION (City or Town) <u>Arlington, Virginia</u> (County) <u>Virginia</u> (State) <u>DC</u>			
24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Ave.</u> <u>Warren E. Pamphrey, Inc.</u> Silver Spring, Md.		25a. REC'D BY REGISTRAR <u>APR 18 1967</u>	25b. SECRETARIAL SIGNATURE <u>Charles Judge</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05421

## CERTIFICATE OF DEATH

05419

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the hospital or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY IN 1b <b>2 3/4 hrs</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital or Silver Spring</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>William C. Manser</b>			First	Middle	Last
4. DATE OF DEATH <b>4/22/67</b>	Month	Day	Year		
5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>8/6/1916</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Woodward &amp; Lothrop</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William C. Manser</b>			14. MOTHER'S MAIDEN NAME <b>Harriet Astbury</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>234-10-3337</b>		
17. INFORMANT <b>Buckhannon Poling St. Clair Funeral Home W. Virginia</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCER OF LUNG</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>163X</b> (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>4/18/67</b> to <b>4/22/67</b> , that (I) (we) last saw the deceased alive on <b>4/18/67</b> , and that death occurred at <b>4/22/67</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>David Goldensher</b>			22b. DATE SIGNED <b>4/22/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>David Goldensher</b>			22d. ADDRESS <b>10620 Georgia Ave., Silver Spring, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Trans-Burial</b>		23b. DATE THEREOF <b>Apr 22, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Heavner Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Buckhannon, West Virginia</b>		23e. ADDRESS <b>8434 Georgia Avenue</b>		23f. REC'D BY REGISTRAR <b>APR 27 1967</b>	
24. FUNERAL DIRECTOR <b>Clark E. Wisor</b>		24b. ADDRESS <b>Concordia</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24c. PUMPHREY, Inc.		24d. ADDRESS <b>Warren E. Pumphrey, Inc.</b>		25c. ADDRESS <b>Silver Spring, Md.</b>	

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ALUMINUM

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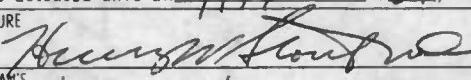
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05422		05420	
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> 6 YRS		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1001 FOREST GROVE DR.</b> SILVER SPRING MD		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> 15-1	
f. STREET ADDRESS <b>1001 FOREST GROVE DR.</b> SILVER SPRING		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT GUSTON MARMADUKE</b>		First <b>G</b> Middle <b>GUSTON</b> Last <b>MARMADUKE</b>	4. DATE OF DEATH Month <b>APRIL</b> Day <b>17</b> Year <b>1967</b>
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/20/74</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Road Construction</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STATE OF VA</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WESTMORELAND, VIRGINIA USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ROBT. VENTON MARMADUKE</b>		14. MOTHER'S MAIDEN NAME <b>OLIVIA SANDERS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>329-18-4857</b>	
17. INFORMANT <b>DAUGHTER - MRS G. SANDERS</b>		Address <b>1001 FOREST GROVE DR.</b> SILVER SPRING	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO <b>4200</b> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) <b>WITH TERMINAL PNEUMONIA</b> DUE TO (c)		20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>CONGESTIVE HEART FAILURE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NO</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) —	
20c. TIME OF INJURY Month, Day, Year Hour o.m. — 19 p.m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , to <b>4/17</b> , 1967, that (I) (we) last saw the deceased alive on <b>4/17</b> 1967, and that death occurred at <b>800K</b> from causes and on the date stated above.		22. DATE SIGNED <b>4/17/67</b>	
22o. SIGNATURE 		22b. ADDRESS <b>1001 GEORGIA AVE SILVER SPRING</b>	
22c. PHYSICIAN'S NAME (Type) <b>HENRY W. STOUT MD</b>		22d. ADDRESS	
23o. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 20, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>Glen Carter</b> ADDRESS <b>8434 Georgia Avenue</b> <b>Warner L. Pumphrey, Inc. Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE PR 20 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

02450

CERTIFICATE OF MAIL

02450

**M** 1  
 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, air removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05423

CERTIFICATE OF DEATH

05421

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>2545 Hillsman Street</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>George Thomas MARSHALL</b>		First	Middle	Lost	4. DATE OF DEATH <b>April 3 1967</b>	Month	Day	Year	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Dec. 14, 1966</b>		9. AGE (In years last birthday) <b>3 yrs.</b>	IF UNDER 1 YEAR <b>3 Months</b>	IF UNDER 24 HRS. <b>Days</b>	Hours <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, if born elsewhere) <b>Force Maryland Andrews Air Force Base</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Robert M. Marshall</b>				14. MOTHER'S MAIDEN NAME <b>Grace Evelyn Harrison</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give name & dates of service) <b>No N/A</b>			16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Falls Church</b> Address <b>Virginia</b> <b>CDR Robert M. Marshall, 2545 Hillsman St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Meningomyelocele with hydrocephalus and ventriculitis</b> DUE TO 751.2 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) _____ DUE TO lost. (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>(F)</b> (this hospital) attended the deceased from <b>March 28, 1967</b> , to <b>April 3, 1967</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>April 3, 1967</b> , and that death occurred at <b>230A M</b> , from causes and on the date stated above.									
22a. SIGNATURE <i>Jerry J. Tomasovic</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>April 3, 1967</b>					
22c. PHYSICIAN'S NAME (Type) <b>Jerry J. Tomasovic, M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>			
24. FUNERAL DIRECTOR <b>James J. Hayes</b>		ADDRESS <b>Falls Church Funeral Home, 1102 West Broad St.</b>		DATE <b>APRIL 10 1967</b>		RECORDED BY <b>John J. Hayes</b> SIGNATURE			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>			c. LENGTH OF STAY IN lb			b. COUNTY <b>MONTGOMERY</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING 15-1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANITARIUM AND HOSPITAL</b>						d. STREET ADDRESS <b>9304 PINEY BRANCH</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>MR. JULIAN WOODROW</b>		First	Middle	Last	4. DATE OF DEATH Month <b>MAY</b>	Month <b>APRIL</b>	Day <b>5</b>	Year <b>1967</b>			
5. SEX <b>MALE</b>		6. COLOR, OR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 20, 1915</b>	9. AGE (in years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GOVERNMENT worker U.S. Gov't.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>			11. BIRTHPLACE (Country & State, or foreign country) <b>Maryland D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John H. May</b>			14. MOTHER'S MÄDEN NAME <b>Claire Conley</b>			Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW II</b>			16. SOCIAL SECURITY NO. <b>214-14-8606</b>			17. INFORMANT <b>Chart Hospital Records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Pulmonary artery embolus</b> INTERVAL BETWEEN DUE TO <b>4200</b> ONSET AND DEATH <b>4 hours</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Embolization of legs</b> UNKNOWN (c) <b>Arteriosclerotic heart disease</b> KNOWN <b>1 hr</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) ( <b>Dr. Traum</b> ) attended the deceased from <b>March 27, 1967</b> , to <b>April 5, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 5, 1967</b> , and that death occurred at <b>107 AM</b> , from causes and on the date stated above.											
22a. SIGNATURE <b>Aaron H. Traum</b>											
22c. PHYSICIAN'S NAME (Type) <b>Dr. Traum</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>April 6, 1967</b>					
23a. BURIAL, CREMATION, BEMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>4/10/67</b>			23c. NAME OF CEMETERY OR CEMETORY <b>Baltimore National</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore Baltimore Md.</b>		
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>						ADDRESS			25a. REC'D BY REGISTRAR <b>APR 10 1967</b>		
									25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05425

## CERTIFICATE OF DEATH

05423

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross of Silver Spring</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>James</b>	Middle <b>W.</b>	Last <b>McARRICK</b>	
4. DATE OF DEATH Month <b>April</b>	Day <b>28</b>	Year <b>1967</b>		
5. SEX <b>M.</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 30 1911</b>	
9. AGE (In years last birthday) <b>76 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Macon, Georgia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick Mc Carrick</b>	14. MOTHER'S MAIDEN NAME <b>Mary Cannon</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>904-05-5034</b>	17. INFORMANT <b>Earlean Mc Carrick</b>	Address <b>1507 Crest Road Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Myocardial Infarction</b> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Arteriosclerosis</b> ONSET AND DEATH (c) <b>Heart Disease</b> <b>2 years</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bronchitis</b> <b>Emphysema</b>				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>James</b> <b>1967</b> <b>April 6, 1967</b> <b>to</b> <b>1967</b> <b>that (I) (we) last saw the deceased alive on April 28, 1967, and that death occurred at 3:45 AM from causes and on the date stated above.</b>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>New Orleans, La.</b>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>James</b> <b>1967</b> to <b>April 6, 1967</b> that (I) (we) last saw the deceased alive on <b>April 28, 1967</b> , and that death occurred at <b>3:45 AM</b> from causes and on the date stated above.		22b. DATE SIGNED <b>4/28/67</b>		
22a. SIGNATURE <b>John J. Curry</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS <b>10620 Georgia Ave., Md.</b>	
22c. PHYSICIAN'S NAME (Type) <b>John J. Curry</b>		23d. LOCATION (City or Town) (County) (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Trans-Burial</b>		23b. DATE THEREOF <b>May 2, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Roch's Cemetery</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Glen E. Pumphrey, Inc.</b>		24a. ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>	25a. REC'D BY REGISTRAR <b>DATE</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
			<b>MAY 1 1967</b>	

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE								
Montgomery Maryland			Md.								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			b. COUNTY								
Takoma Park			Montgomery, Md.								
c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)								
1 month			Deluxe Diner Inn, Md.								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS								
Oak Haven Convalescent Home			8200 N.H. Ave.								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH						
Eva		F.	Mc Chesney	April	28 1967						
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)						
F.		W		Oct 20, 1872	94 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY								
Bureau of Engraving U.S. Gov't			11. BIRTHPLACE (County & State, or foreign country)								
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY								
Joseph Nicholson			U.S.								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT							
No		—		Mrs. May, 8200 New Hampshire Ave., Silver Spring, Md.							
Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
4341 Cerebrovascular accident											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO (b) Old age; cachexia + weakness, Bedridden (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
INTERVAL BETWEEN ONSET AND DEATH 2-3 days											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
19				1967, to 7/28/1967, that (I) (we) last saw the deceased alive on 7/27/1967 and that death occurred at 6:45 AM, from the causes and on the date stated above.							
21. I certify that (I) (this hospital) attended the deceased from		22b. DATE SIGNED									
22a. SIGNATURE		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS									
Chas H W. Lohon		7401 Blue Rd NW									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL							
cremation 4/29/67		Fort Lincoln Cemetery, Bladensburg, Md.		(State)							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR							
W.W. Chambers, Inc.		8655 Ga. Ave. SS MD.		25b. REGISTRAR'S SIGNATURE							
25a. REC'D BY REGISTRAR		DATE		25b. REGISTRAR'S SIGNATURE							
MAY 4 1967		1967		j Charles Judge							

15220

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

B P 2  
B P

05427

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05425

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> , MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park.</u>		c. LENGTH OF STAY IN lb <u>5 days.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u>		First <u>John</u>	Middle <u></u>
		Lost <u></u>	4. DATE OF DEATH Month <u>April</u> Doy <u>15</u> Year <u>1967</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/26/02</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	9. AGE (In years lost birthday) <u>65 yrs.</u>
13. FATHER'S NAME <u>David P. McCloschan</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>1919-1921</u>		16. SOCIAL SECURITY NO. <u>71814-9712</u>	17. INFORMANT <u>Mr. John McCloschan</u> Address <u>Ashley</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-Pontine Hemorrhage &amp; Thrombosis</u> DUE TO <u>Middle-Cerebral Artery Left -</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u> (b) <u>Coronary Insufficiency Severe</u> <u>years.</u> (c) <u>Arteriosclerosis generalized Severe</u> <u>years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anesthesia for Manipulation to free Shoulder</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>General anesthesia-increased strain on Vascular system</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		20f. (City or town) <u>Burtsassville</u> (County) <u>Md.</u> (State)	
ACTUAL SIGNATURE <u>John B. Bell</u> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>4-18-67</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Stevens Crem</u>
24. FUNERAL DIRECTOR <u>Walt Donaldson</u>		ADDRESS <u>1 Burtsassville Rd</u>	23d. LOCATION (City or Town) <u>Burtsassville Md</u> (County) <u>Md.</u> (State)
		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
		DATE <u>APR 20 1967</u>	

530

and was a single component of a microRNA  
in most tissues, except testis.

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05428

## CERTIFICATE OF DEATH

05426

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial-cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>	c. LENGTH OF STAY IN lb <b>D.O.A.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		d. STREET ADDRESS <b>508 Wayne Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Loretta</b>	Middle <b>E.</b>	Last <b>Mc Donnell</b>
4. DATE OF DEATH Month <b>April</b>	Month <b>4</b>	Doy <b>1967</b>	Year
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>April 25, 1905</b>		9. AGE (In years lost birthday) <b>61 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Financial Sec. &amp; Treas.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fidelity Properties Pennsylvania</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>John M. Crowley Crawley</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Windle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>Yes</b>	
17. INFORMANT <b>James A. Mc Donnell</b>		Address <b>508 Wayne Avenue Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>4201</b>		INTERVAL BETWEEN ONSET AND DEATH <b>few months</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause <b>coronary thrombosis</b>			
(b) DUE TO <b>coronary atherosclerosis</b>			
(c) DUE TO <b>coronary atherosclerosis</b>		7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Diabetes Mellitus onset 1954</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter letter of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 20, 1967</b> , to <b>April 7, 1967</b> , that (I) (we) last saw the deceased alive on <b>Mar 29 1967</b> , and that death occurred at <b>250A M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>4/4/67</b>	
22a. SIGNATURE <b>Michael M. Healy</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS <b>WASHINGTON CLINIC, WASH, D.C.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 8, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas, Jr.</b>		ADDRESS <b>8434 Georgia Avenue Warren E. Pumphrey, Inc. Silver Spring, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>APR 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

6920

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05423

## CERTIFICATE OF DEATH

05427

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages A and B should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery P.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN lb <u>D. O. A.</u>		d. STREET ADDRESS <u>7107 14th Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Peter</u>		First <u>John</u>	Middle <u>Mc Gurr, Jr.</u>
Last <u>April</u>		4. DATE OF DEATH Month <u>April</u>	Day <u>20</u> Year <u>19 67</u>
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>July 20, 1921</u>		9. AGE (In years last birthday) <u>45 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. M. Workers</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter J. Mc Gurr, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Rose Burke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>175-12-9578</u>	
17. INFORMANT <u>Regina Mc Gurr</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Dystarctism</u> INTERVAL BETWEEN ONSET AND DEATH <u>Summed.</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <u>Cov. Prv. Dis</u> DUE TO <u>2 months</u> (c)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Silver Spring</u> (County) <u>Maryland</u> (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 1967, to <u>Apr 20</u> , 1967, that (I) (we) last saw the deceased alive on <u>Apr 18</u> 1967, and that death occurred at <u>9:45 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>James J. Foster</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4/20/67</u>
22c. PHYSICIAN'S NAME (Type) <u>James J. Foster</u>		22d. ADDRESS <u>1746 K St N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr 24 1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Gate of Heaven Cemetery</u>
24. FUNERAL DIRECTOR <u>Jean Carter Glens Falls</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>	
8434 ADDRESS <u>Warren E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 27 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>

TSI20

TSI20

TSI20

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05430		05428	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring, Md.</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Colonial Villa Nursing Home</i>		d. STREET ADDRESS <i>3304 Runnymede Place N.W.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>First Edna Middle Webb</i>		4. DATE OF DEATH <i>Lost Miles</i>	Month <i>4</i> Doy <i>22</i> Year <i>1967</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-20-82</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>- - -</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James A. Webb</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Snyder</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>- - -</i>	
17. INFORMANT <i>Walter Miles, Jr. See Item #2-</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i> DUE TO <i>193X</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Pneumonia</i> DUE TO		(c)	
3 dyc			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Parkinson's Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2/26, 1967</i> , to <i>4-22, 1967</i> , that (I) (we) last saw the deceased alive on <i>4-20, 1967</i> , and that death occurred at <i>2:25 AM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>4-22-67</i>	
22a. SIGNATURE <i>R.H. Sandstrom</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>R. H. Sandstrom MD</i>		22d. ADDRESS <i>7701 Carroll Ave Takoma Park MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-25-1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Rock Creek Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR <i>Gawler's Sons, Inc.</i>		25a. ADDRESS <i>5130 Wisconsin Ave. N.W.</i>	
25b. DATE <i>APR 26 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05431

CERTIFICATE OF DEATH

05429

1. PLACE OF DEATH a. GDUNTY	Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Takoma Park 5½ yrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b			d. STREET ADDRESS Silver Spring 151 8825 Glenville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	Oakhaven Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Oscar	Middle R.	Last Miller	4. DATE OF DEATH April 8 1967
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12 1878 88 yrs.	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postman	10b. KIND OF BUSINESS OR INDUSTRY U.S. govt	11. BIRTHPLACE (County & State, or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Miller	14. MOTHER'S MAIDEN NAME Mary Ryan	Address Mc. 577-36-1414 Mrs. Helen Colvin, 841 First Ave. Silver Spring		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No	16. SOCIAL SECURITY NO. 577-36-1414	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.				
DUE TO (b)	Congestive heart failure due to arteriosclerosis			
DUE TO (c)	Old cerebral thrombosis & paraparesis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/15/1967 to 4/8/1967, that (I) (we) last saw the deceased alive on 4/7/1967, and that death occurred at 4/8/1967, M, from the causes and on the date stated above.				
22a. SIGNATURE Chas H. Wolton	22b. DATE SIGNED apr 8, 1967			
22c. PHYSICIAN'S NAME (Type) Chas H. Wolton	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 7401 Blk Rd NW Wash DC		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 11, 1967	23c. NAME OF CEMETERY OR CREMATORIAL National Memorial Park	23d. LOCATION (City, town or county) Falls Church, Virginia (State)	
24. FUNERAL DIRECTOR Dr. Arthur Walters, 254 Carroll St NW Wash. D.C.	ADDRESS	25a. REG'D BY REGISTRAR APR 13 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

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30132

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05432

CERTIFICATE OF DEATH

05430

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE	
<i>Montgomery Maryland</i>		<i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Bethesda</i>		<i>30 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>Suburban Center</i>		<i>807 Grandin Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Carter</i>		<i>W.</i>	<i>mills, sr.</i>
Last		4. DATE OF DEATH	Month
		<i>4-7</i>	Doy
		Year	<i>1967</i>
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH
<i>m</i>	<i>gr</i>	<i>5-21-08</i>	9. AGE (In years last birthday) <i>58 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>No</i>		<i>WESTERN Elec.</i>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<i>Virginia</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>George C. Mills</i>		<i>Sutherland T. Latham</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> yes give war or dates of service		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>577-07-8535</i>	
17. INFORMANT		Address	
<i>Wife - Olive - same</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSLED AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>1621</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) } (c) }		<i>Cerebral metastases</i>	
DUE TO		<i>1mth</i>	
DUE TO		<i>5 yrs.</i>	
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1962</i> to <i>4-7, 1962</i> , that (I) (we) last saw the deceased alive on <i>4-6 1962</i> , and that death occurred at <i>7A M</i> , fram causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
<i>DC Buddy</i>		<i>4-7-67</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
<i>DC Buddy</i>		<i>809 Lewis Mill Rd Rockville Mont</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<i>Burial</i>		<i>4-10-67</i>	
23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town) (County) (State)	
<i>Rockville Cemetery</i>		<i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR		25a. RECD BY REGISTRAR	
ROBERT A. PUMPHREY, Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE	
		<i>Charles Judge</i>	

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FOR STATE  
HEALTH DEPT.

05433

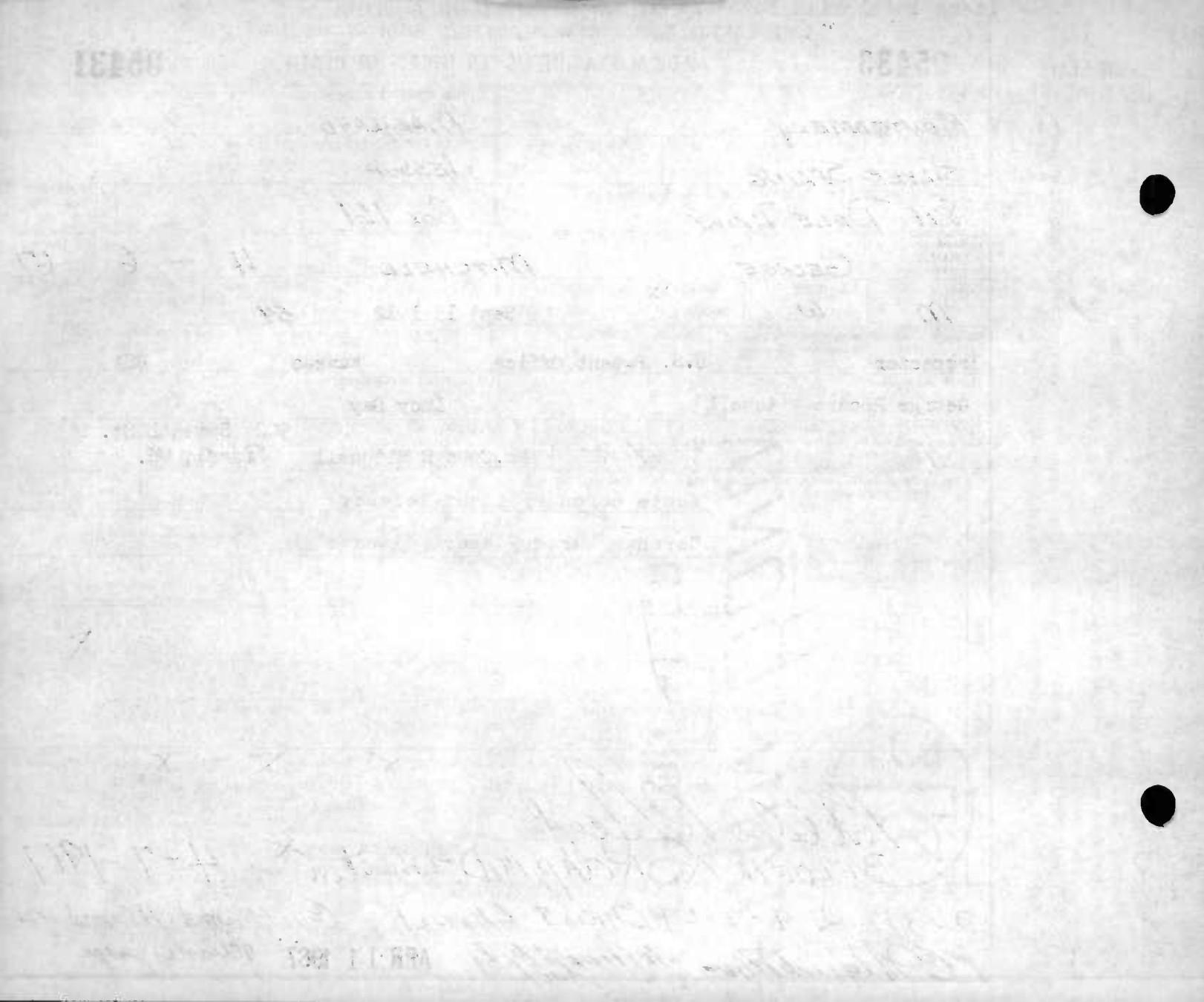
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05431

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Howard</b>	
c. LENGTH OF STAY IN lb <b>811 DALE Drive</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>JESSUP</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>Box 161</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>GEORGE</b>	Middle <b></b>	4. DATE OF DEATH <b>4 - 6 1967</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 13 1912</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Patent Office</b>	
11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Robert Mitchell</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Day</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. John R Mitchell</b>		902 <del>Seventh St.</del> Laurel, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery heart disease</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>
20f. (City or town) <b></b>		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belton R. Leach</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <b>BELTON R. LEAP, M.D., Atherton</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or county) <b></b>	
22. DATE SIGNED <b>4-7-1967</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-9-67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Christ Church</b>		23d. LOCATION (City or Town) <b>Bell Ford Howard</b>	
24. FUNERAL DIRECTOR <b>FCO Funeral Home</b>		ADDRESS <b>11100 G St</b>	
25a. REC'D BY REGISTRAR <b>APR 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20 Film 387 4-18-67 MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #0387 L171767 by

05434

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Resident before admission) b. STATE	
Montgomery MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		d. STREET ADDRESS L.F.I.L #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Eugene Oscar Mobley		Lost	4. DATE OF DEATH
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
Male	Nevada	5/12/113	9. AGE (In years 53 (lost birthday) yrs.
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		11. BIRTHPLACE (State or foreign country) Chesapeake Maryland (Montgomery Co.)	
13. FATHER'S NAME Bud		14. MOTHER'S MAIDEN NAME Mobley Mary Tyson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Address: Same as above Cousin - Shirley Newman			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9160 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		Lobular Pneumonia, Bilateral BURNS, 2nd + 3rd. DEGREE Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fatty Metamorphosis, Liver			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 11/14/1967		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 11/14/1967	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 2:20 AM 3/20 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Gaithersburg Montg Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Laytonsville, Md.	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 4-12-67	
23c. NAME OF CEMETERY OR CREMATORIAL Brooke Grove.,		23d. LOCATION (City or Town) (County) (State) Laytonsville, Md.	
24. FUNERAL DIRECTOR Robert L. Snowden		ADDRESS Rockville, Md.	
		25a. REC'D BY REGISTRAR DATE APR 13 1967	
		25b. REGISTRAR'S SIGNATURE James J. Moore	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

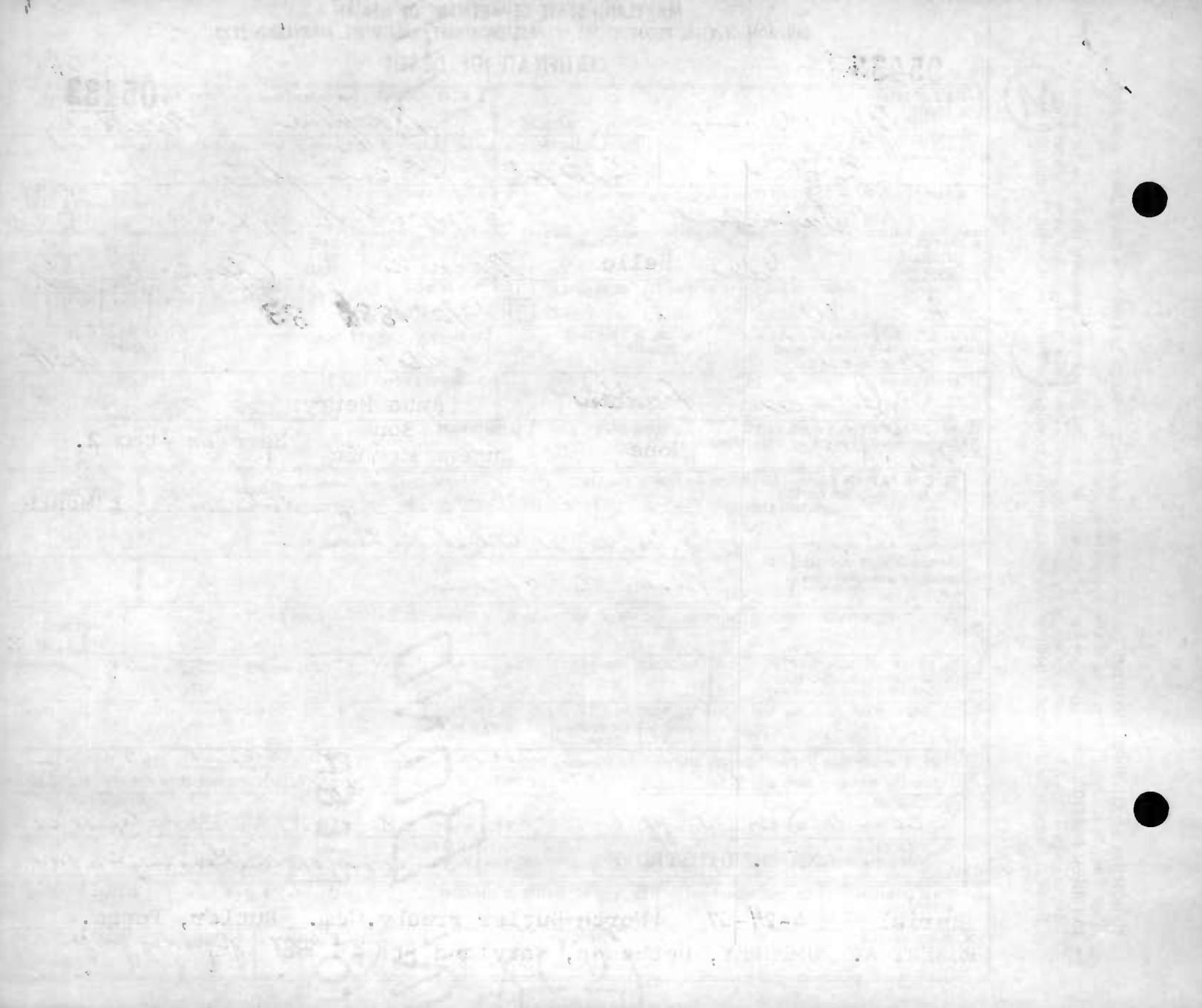
CERTIFICATE OF DEATH

05435

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial/cremation, or removal of any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		d. STREET ADDRESS <i>11208 Silver Rd.</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Saberton</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>Ida</i>	Middle <i>Belle</i>	Last <i>Monnie</i>	4. DATE OF DEATH <i>April 20</i>	Month <i>April</i>	Day <i>20</i>	Year <i>1967</i>		
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/28/1883</i>	9. AGE (In years last birthday) yrs. <i>83</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Oa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>James</i>		14. MOTHER'S MAIDEN NAME <i>Patterson</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Son <i>Eugene Monnie</i>		Address <i>Same as Item 2.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio. sclerotic</i>		DUE TO <i>Prob - C.V.A - Congestive failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 Month</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>1538</i>		(b) DUE TO <i>Intestinal Obstruction</i>								
		(c) DUE TO <i>Prob Ca. Colon</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>23 March</i> , 19 <i>67</i> , to <i>20 April</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>7/18</i> 19 <i>67</i> , and that death occurred at <i>429 M</i> , from causes and on the date stated above.										
22a. SIGNATURE <i>Ann M. Dimitroff</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>20 April '67</i>		
22c. PHYSICIAN'S NAME (Type) <i>ANN M. DIMITROFF</i>		22d. ADDRESS <i>11300 Woodson Ave Kensington Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-24-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>North Butler Presby. Cem. Butler, Penna.</i>		23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS		25a. REC'D. BY REGISTRAR <i>APR 24 1967</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>						05434		
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE					
<i>Montgomery</i> MARYLAND			<i>Maryland</i> b. COUNTY			<i>St. Mary's</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
<i>Kensington</i>			3 YRS 6 mo			<i>California</i> , 18-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<i>Kensington Gardens</i>								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Doy	Year
<i>Bessie Jane</i>				<i>Moore</i>	<i>April 27</i>			<i>1967</i>
5. SEX		6. COLOR OR RACE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
<i>Female</i>		<i>White</i>			<i>Aug. 6, 1880</i>	<i>86</i>	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)		
<i>Government Ret'd</i>						<i>Maryland</i>		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			12. CITIZEN OF WHAT COUNTRY?		
<i>Henry Moore</i>			<i>FRANCIS DASSY</i>			<i>USA</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT		
						<i>Jack W. King - Box 27- California Md.</i>		
Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cerebral vas. disease</i> 5 yrs 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arterioclerosis</i> 20 yrs DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (This Hospital) attended the deceased from <i>Dec 16</i> , 1963, to <i>April 27</i> , 1967 that (I) (we) last saw the deceased alive on <i>April 27</i> 1967, and that death occurred at <i>16-16 NW Wash DC</i> M, from causes and on the date stated above.								
22a. SIGNATURE			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>4/27/67</i>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS <i>7852 16-16 NW Wash DC</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>May 1st 1967</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Bells Methodist Cemetery</i>		
23d. LOCATION (City or Town) (County) (State) <i>Camp Springs, Maryland</i>			23e. ADDRESS			23f. REC'D BY REGISTRAR		
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>			24b. ADDRESS <i>1661-Good Hope Rd SE Wash DC</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
25a. DATE <i>MAY 1 1967</i>								

BC460

1955 TO 1956

BC460

FOR STATE  
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Please  
5 may be retained for your files.

16  
2  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05437

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05435

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>2 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash. San &amp; Hospital</i>		d. STREET ADDRESS <i>9924 Woodburn Rd</i>	
3. NAME OF DECEASED (Type or print) <i>Michael Anthony Moyer</i>		First <i>Michael</i>	Middle <i>Anthony</i>
4. DATE OF DEATH <i>4 28 1967</i>		Last <i>Moyer</i>	Month Year
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED NEVER MARRIED WIDOWED DIVORCED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	B. DATE OF BIRTH <i>2-21-45</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Heavy Machine operator</i>		9. AGE (In years last birthday) yrs. <i>22</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>Bldg. Construction</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Robert A. Moyer</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No None</i>		16. SOCIAL SECURITY NO. <i>219-42-3694</i>	
17. INFORMANT <i>Mary G. Moyer</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple skull fractures with</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. <i>821.4</i> (b) <i>cerebral laceration and intracranial</i> DUE TO (c) <i>hemorrhage</i>	
INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Deceased found mortally injured beside wrecked motorcycle on Riggs Road</i>	
20c. TIME OF INJURY Month, Day, Year 2:50 Hour <input checked="" type="checkbox"/> p.m. 4-27 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Street</i>
20f. (City or town) (County) (State) <i>Hyattsville PrGeo Md</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Belden R. Leap</i> M.D. EXAMINER'S NAME (Type) <i>BELDEN R. LEAP, MD. Anesth.</i>			
22. DATE SIGNED <i>4/28/1967</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
23b. DATE THEREOF <i>May 2, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>George Washington Cemetery</i>	
23d. LOCATION (City or Town) (County) (State) <i>Hyattsville, Maryland</i>		23e. ADDRESS <i>8434 Georgia Avenue</i>	
24. FUNERAL DIRECTOR <i>John B. Thomas, Glenelg Home, Warner E. Pumphrey, Inc.</i>		25a. RECD BY REGISTRAR DATE <i>MAY 4 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05438

## CERTIFICATE OF DEATH

05437

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>			d. STREET ADDRESS <u>12321 Manship Lane</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Day Year <u>APRIL 18 1967</u>
S. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 17 1967</u>		9. AGE (In years lost birthday) yrs. <u>6 34</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Joseph Murphy</u>			14. MOTHER'S MAIDEN NAME <u>Polly Daigh</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7735</u> Hyaline membrane disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-17-</u> , 19 <u>67</u> , to <u>4-18-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-18-</u> , 19 <u>67</u> , and that death occurred at <u>12:30 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Albert J. Modlin, M.D.</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Albert J. Modlin, M.D.</u>		22d. ADDRESS <u>704 Gorman Ave., Laurel, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/21/67</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Gate of Heaven</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>APR 24 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TELE

TELEGRAM

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TELEGRAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

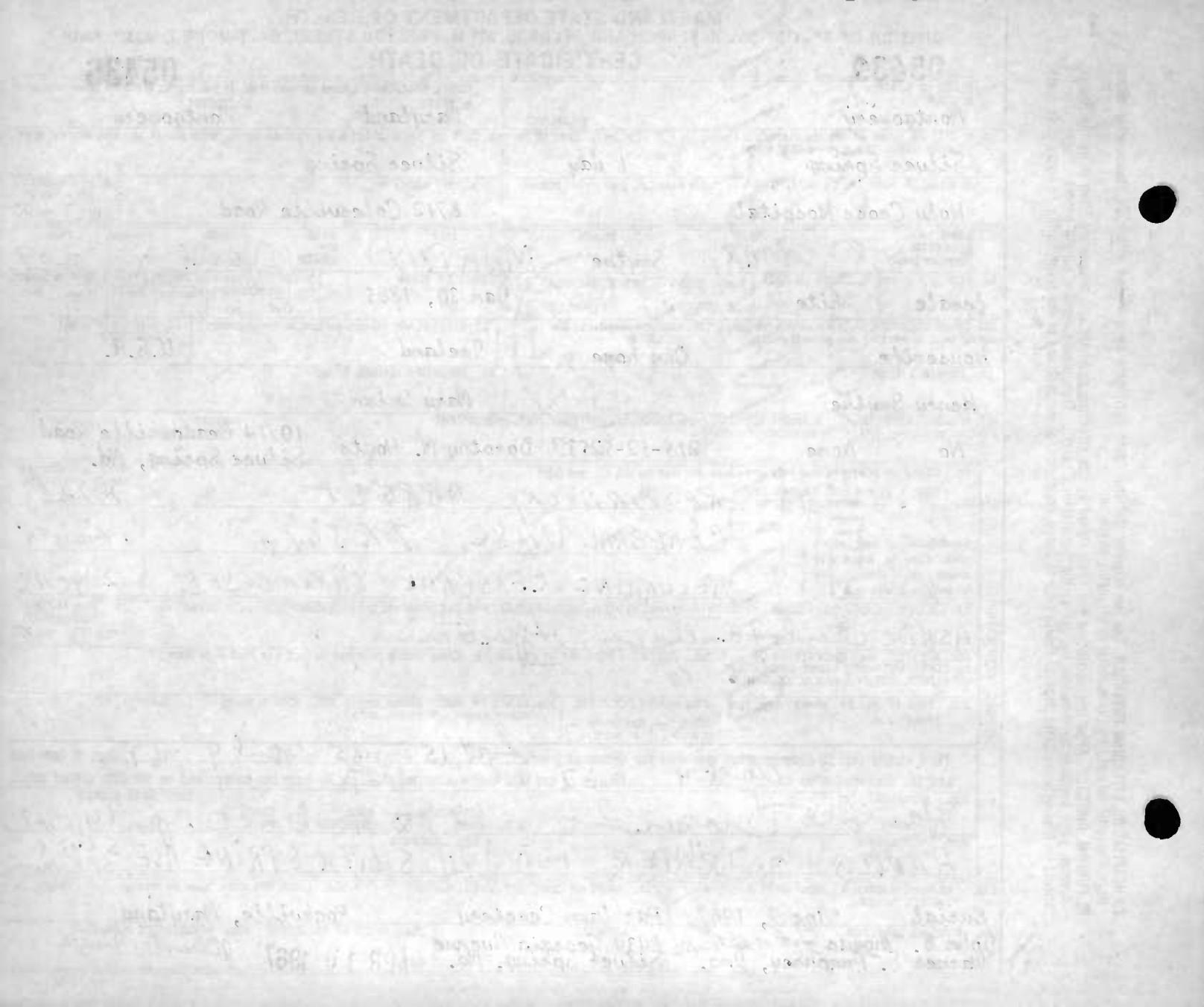
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

25433

CERTIFICATE OF DEATH

05136

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	b. COUNTY <i>Montgomery</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	c. LENGTH OF STAY IN 1b <i>1 day</i>	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	d. STREET ADDRESS <i>8712 Colesville Road</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Holy Cross Hospital</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>MARY Smythe MURPHY</i>	First <i>MARY</i>	Middle <i>Smythe</i>	Last <i>MURPHY</i>	4. DATE OF DEATH Month Day Year <i>April 4 1967</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 30, 1885</i>	9. AGE (in years last birthday) <i>82 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Ireland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Henry Smythe</i>	14. MOTHER'S MAIDEN NAME <i>Mary Quinn</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>215-52-52539</i>	17. INFORMANT <i>Dorothy M. Vogts</i>	Address <i>10714 Meadowhills Road Silver Spring, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RESPIRATORY ARREST</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 mins</i>			
332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CEREBRAL VASC. INSUFF</i>				1 MONTH			
DUE TO (c) <i>RECURRING CEREBRAL THROMBOSIS</i>				2 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>ASHDc atud fibrillation; Hypertension</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Rockville</i>	(County) <i>Maryland</i>	(State) <i>MD</i>		
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 15</i> , 1965, to <i>April 4</i> , 1967, that (I) (we) last saw the deceased alive on <i>April 4</i> , 1967 and that death occurred at <i>82</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Harold W. Draper</i>	22b. DATE SIGNED <i>April 4, 1967</i>						
22c. PHYSICIAN'S NAME (Type) <i>HAROLD W. DRAPER M.D.</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Apr 7, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Parklawn Cemetery</i>	23d. LOCATION (City, town or county) <i>Rockville, Maryland</i>	(State) <i>MD</i>			
24. FUNERAL DIRECTOR <i>John B. Thomas &amp; Son Inc.</i>	ADDRESS <i>8434 Georgia Avenue Warren E. Pumphrey, Inc.</i>	25a. REC'D BY REGISTRAR <i>PR 10 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>																	
05440						05438											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
a. COUNTY <b>Montgomery</b> MARYLAND						b. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)													
<b>BETHESDA</b>		<b>13 1/2 hrs.</b>		<b>BETHESDA</b>													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS											
<b>Suburban.</b>						<b>8604 Brandt Pl.</b>											
3. NAME OF DECEASED First <b>WELTY</b> Middle <b>R</b> Last <b>MURRAY</b>			4. DATE OF DEATH			Month <b>April</b>			Doy <b>18</b> Year <b>1967</b>								
3. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-31-1905</b>		9. AGE (In years <b>61</b> last birthday) yrs.		IF UNDER 1 YEAR							
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>								Months	Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
<b>REAL ESTATE SALESMAN</b>				<b>FRANKS Phillips</b>				<b>Maryland</b>				<b>U. S.</b>					
13. FATHER'S NAME <b>Reginald Murray</b>						14. MOTHER'S MAIDEN NAME <b>Charlotte Young</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>				17. INFORMANT <b>Wife</b>				Address <b>Same as Item 2.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia - Bronchial.</b> DUE TO <b>180X</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b>																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				(b) <b>Carcinoma of Supt. Mta static</b> DUE TO <b>180X</b>								<b>7 yr.</b>					
				(c) <b>Carcinoma of Kidney - Removal.</b> DUE TO <b>180X</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)													
20c. TIME OF INJURY Month, Day, Year Hour: a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Frederick</b>		(County) <b>Maryland</b>		(State) <b>Maryland</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> , 19, to <b>date</b> , 19, that (I) (we) last saw the deceased alive on <b>4/17</b> 1967, and that death occurred at <b>5A</b> M, from causes and on the date stated above.																	
22a. SIGNATURE <b>John G. Ball</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>						MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <b>JOHN G. BALL</b>						22d. ADDRESS <b>7936 Old Georgetown Rd.</b>						<b>4/17/67</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						23b. DATE THEREOF <b>4-21-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) <b>Frederick</b>		(County) <b>Maryland</b>		(State) <b>Maryland</b>			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>						ADDRESS		25a. RECD BY REGISTRAR <b>APR 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Robert George</b>							

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Annotator

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Georgian language

*Journal of Health Politics, Policy and Law*, Vol. 33, No. 4, December 2008  
DOI 10.1215/03616878-33-4 © 2008 by The University of Chicago

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

05439

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE		MD b. COUNTY		Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		25 days		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Takoma Park 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		University Nursing Home		d. STREET ADDRESS		6819 Red Top Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Female		White		Sept 13, 1887	79 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY			
Clerk - Government		Federal Government		York, Penn		U.S.A			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Clayton Myers		Elizabeth Strickhouse							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		597-03-0512		Mr. Perry Schrodern		#2 Crescent Pl. E P.M.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		448X		Cardiac Failure		3 days			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)		Cardiovascular Renal Disease		1 yr			
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 1</u> , 1967, to <u>Apr. 18</u> , 1967, that (I) last saw the deceased alive on <u>Apr. 18</u> , 1967, and that death occurred at <u>2:45 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE						22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				LYNWOOD HIGGS, M.D., F.A.C.A.		4/18/67			
23a. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)		(State)	
Burial		Apr. 21-1967		Ft. Lincoln		Washington 22, D.C.		D.C.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Arthur Kettner		25 Carroll St.		APR 21 1967		Charles J. ...			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

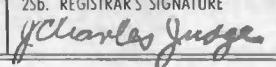
To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05442

CERTIFICATE OF DEATH

05440

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Virginia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Carl</b>		First <b>Carl</b>	Middle <b>Martin</b>
4. DATE OF DEATH <b>April 1, 1967</b>		Last <b>NAGLE</b>	Month Doy Year 1 19 67
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Jan. 11, 1911</b>		9. AGE (In years last birthday) <b>56 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Belair, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Bernard Nagle</b>		14. MOTHER'S MAIDEN NAME <b>Mary Carl</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1927-1958</b>	
17. INFORMANT <b>Fairfax</b>		Address <b>Virginia</b>	
		Mrs. Wilmoth G. Nagle, 10570 Main St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Alveolar cell carcinoma, lung</b>		INTERVAL BETWEEN ONSET AND DEATH	
1621 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Bronchopneumonia</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 30, 1967</b> , to <b>April 1, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 1, 1967</b> , and that death occurred at <b>10:27 P.M.</b> from causes and on the date stated above.		22. DATE SIGNED <b>April 3, 1967</b>	
22a. SIGNATURE 		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>
22c. PHYSICIAN'S NAME (Type) <b>Peter T. Kirchner, M.D.</b>		23d. LOCATION (City or Town) (County) (State) <b>Spotsylvania County, Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Sunset Memorial Gardens</b>
24. FUNERAL DIRECTOR 		25a. REC'D BY REGISTRAR <b>APR 4 1967</b>	25b. REGISTRAR'S SIGNATURE 
Elkins Funeral Home, Fredericksburg, Virginia			

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Page 3 of 36 07201

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### REFERENCES

### Table 1. *Experiments*

• 4 • 55002210-2052

• 11 • *Journal of Cultural Geography*

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.



10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

35443

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05441

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
<i>Montgomery</i> <i>Maryland</i>		<i>T. C.</i> <i>b. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb d. STREET ADDRESS	
<i>Bethesda</i> <i>Rural</i>		<i>Washington</i> <i>4901-Glenbrook Rd.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Suburban</i>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Margaret Darby Nixon</i>			Last
4. DATE OF DEATH		Month	Year
		April	22 1967
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>Female</i> <i>White</i>			
8. DATE OF BIRTH		9. AGE (in years (last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.
<i>Oct. 22 1895</i>		<i>71</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>none</i>			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Washington, D.C.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Rufus Hilton Darby</i>		<i>Doris Frances Clark</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>- - -</i>	
17. INFORMANT		18. INTERVAL BETWEEN ONSET AND DEATH	
<i>John Wilson</i>		<i>5 min.</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
<i>9216</i>		<i>Death by Foreign body causing an</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<i>hypoflexion &amp; fracture</i>	
20c. TIME OF INJURY Month, Day, Year Hour		20d. INJURY OCCURRED While Not While of work <input type="checkbox"/> of work <input type="checkbox"/> of work	
<i>7:59 p.m. 4 22 1967</i>		<i>County Club Bethesda, Md.</i>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or Town) (County) (State)	
<i>County Club Bethesda, Md.</i>			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED	
ACTUAL SIGNATURE: <i>John S. Rogers MD</i>		22. DATE SIGNED <i>4-23-67</i>	
EXAMINER'S NAME (Type) <i>John S. Rogers MD</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-25-1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL CEM. <i>Arlington Nat'l. Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Arlington, Va.</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i>		25a. ADDRESS <i>5130 Wisconsin Ave. N.W. Wash. D.C.</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
		25c. REC'D BY REGISTRAR <i>APR 26 1967</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2 Film G388 4/28/67 hr

05444

## CERTIFICATE OF DEATH

05442

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> P.G. b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY IN lb 7 mos. 12 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fairland Nursing Hom•</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Nobia</b>			First	Middle	Last <b>Neal</b>
4. DATE OF DEATH <b>April 19 1967</b>			Month	Day	Year
5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/27/1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) <b>Graves Co., Ky.</b>
13. FATHER'S NAME <b>Thomas Holt Cosby</b>			14. MOTHER'S MAIDEN NAME <b>Belloria Gough</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>220-54-0333</b>		
17. INFORMANT <b>Mr. O.T. Neal - St., Mt. Rainier, Md.</b>			Address <b>4104 - 31st</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A.S.C.V.D.</b> 4221 DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Seiz'l arteriosclerosis</b> DUE TO (c) <b>Senility</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bronchopneumonia 2/10/67 - 2/22/67</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>1/28, 1967 to 4/19/67, 1967</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <b>Colmar Manor, Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>4/12 1967</b> and that death occurred at <b>9:45 AM</b> , from causes and on the date stated above.		20f. (City or town) (County) (State)			
22o. SIGNATURE <b>J M Warren</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/19/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J M Warren</b>		22d. ADDRESS <b>305 Prince St Laurel</b>			
23o. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/22/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Com.</b>	
24. FUNERAL DIRECTOR <b>Nally's Funeral Home Inc.</b>		ADDRESS <b>Mt. Rainier, Maryland</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
				25o. REC'D BY REGISTRAR DATE <b>APR 25 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10/10/02 201 3/4  
Puffins  
10/10/02 201 3/4  
Herring Gulls

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05445

**CERTIFICATE OF DEATH**

05443

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>MONTGOMERY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY, MD</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b> 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL</b>			d. STREET ADDRESS <b>RT 1 Box 196</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED First <b>BESSIE</b> Middle <b>GAVER</b> Last <b>NEHOUSE</b>			4. DATE OF DEATH <b>APRIL 16 1967</b>		
S. SEX <b>F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-9-89</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months Doy Hours Min. 
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co., Md.</b>	
13. FATHER'S NAME <b>WILLIAM BURDETTE</b>			14. MOTHER'S MAIDEN NAME <b>SALLY HILTON</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hilton B. Nehouse, Item 2</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO <b>4201</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic cardio-vasc. disease</b> DUE TO yrs. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus, broncho pneumonia</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-3-67, 19</b> to <b>4-16, 1967</b> , that (I) (we) last saw the deceased alive on <b>4-15 1967</b> , and that death occurred at <b>5 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Frederick Moorman</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED <b>4-16-67</b>					
22b. PHYSICIAN'S NAME (Type) <b>Frederick Moorman, M.D.</b>		22d. ADDRESS <b>Medical Center, Sandy Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 19, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Salem Meth.</b>	
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>APR 20 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05446

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>MONTgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>M.D.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN lb <b>10 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASH SAN + Hospt</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Noelle Cornelius NORFOLK</b>		First	Middle
4. DATE OF DEATH Month <b>4</b> Day <b>1</b> Year <b>1967</b>		Lost	Year
S. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>April 19, 1912</b>		9. AGE (In years) lost birth <b>54</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Heavy Equipment Oper.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Roads</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>XXXXXXXXXX</b>	
17. INFORMANT <b>Larry Norfolk</b>		Address <b>30 Park Rd. Riviera Beach Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1621</b> DUE TO <b>Bronchopneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <b>Bacterial infection &amp; destruction</b> lost. (c) DUE TO <b>Bronchogenic carcinoma</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Pulmonary emphysema; Laennec's cirrhosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>(</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/22</b> , 19 <b>67</b> , to <b>4/1</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>4/1</b> , 19 <b>67</b> and that death occurred at <b>700</b> M, from causes and on the date stated above.		22b. DATE SIGNED <b>4-3-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Kenneth Kenneth Cruze</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>831 University Blvd E. Md. Silver Spr.</b>
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-5-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL Cem.: <b>Washington National</b>
24. FUNERAL DIRECTOR <b>Ritchie Bros. Funeral Home Maryland</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md. Pr. Geo.</b>	
25a. REC'D BY REGISTRAR DATE <b>APR 4 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

42 SERIAL LINE

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05445

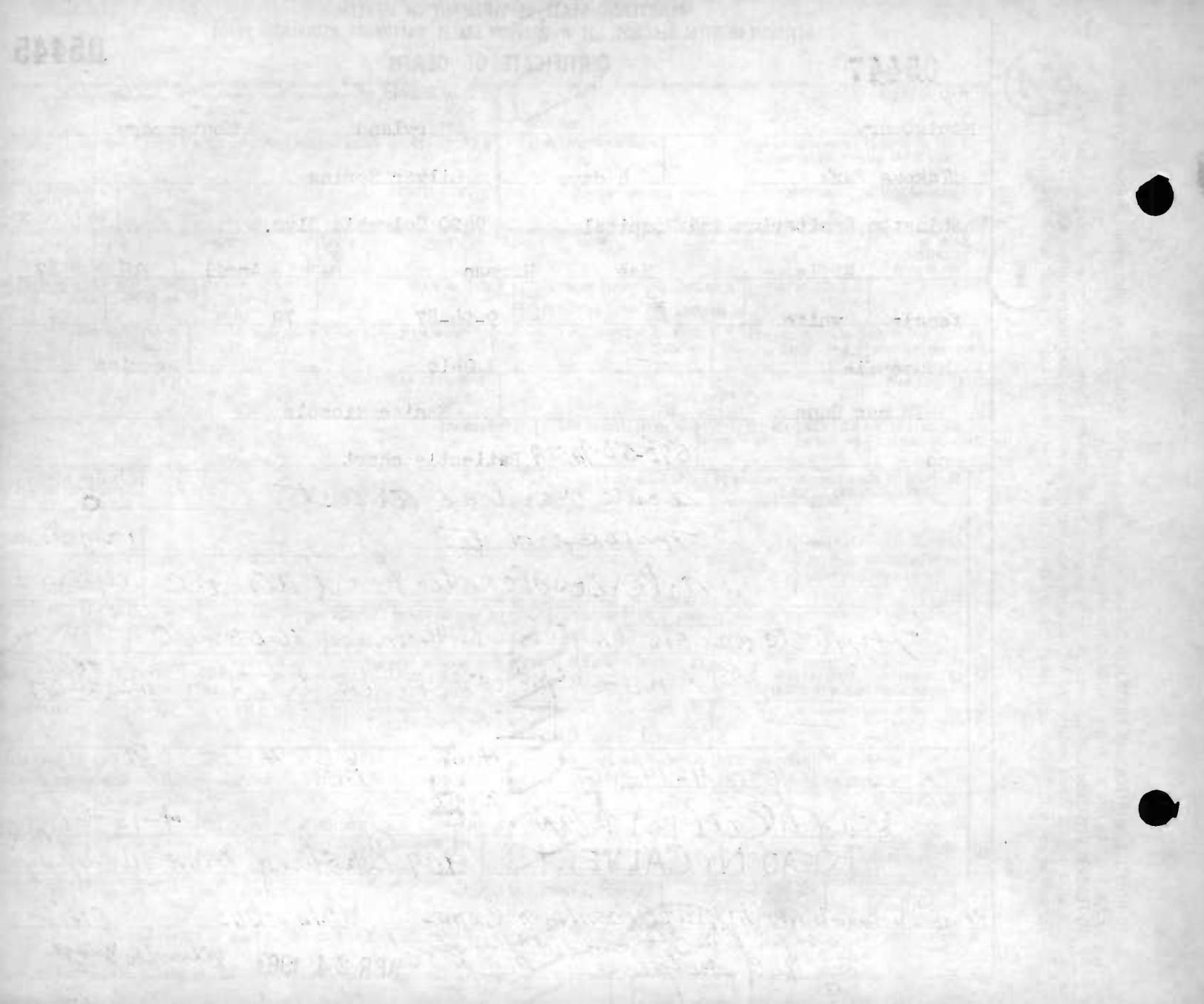
05447

**CERTIFICATE OF DEATH**

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1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> 14 days		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9. AGE (In years last birthday) yrs. <b>79</b>	
3. NAME OF DECEASED (Type or print) <b>Effie Mae Norman</b>		4. DATE OF DEATH Month Day Year <b>April 15 1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>9-21-87</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Thomas Gunn</b>		14. MOTHER'S MAIDEN NAME <b>Eunice Nichols</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-50-9432A</b>	
17. INFORMANT <b>Patient's chart</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute cardiac arrest</b> DUE TO <b>myocarditis</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 years ±</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Hypertension (systolic B.P.-varied 160 to 260</b> DUE TO <b>arteriosclerotic heart disease</b> <b>10 years ±</b> stating the underlying cause (c) <b>hypertension</b> <b>hypertension</b> <b>hypertension</b> <b>hypertension</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension (systolic B.P.-varied 160 to 260</b> <b>hypertension</b> <b>hypertension</b> <b>hypertension</b> <b>hypertension</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>nc</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>—</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>
21. I certify that (I) (this hospital) attended the deceased from <b>4-11-67</b> to <b>4-15-67</b> , that (I) (we) last saw the deceased alive <b>4-14-1967</b> , and that death occurred at <b>1:15 AM</b> , from causes and on the date stated above.		20f. (City or town) <b>—</b> (County) <b>—</b> (State) <b>—</b>	
22a. SIGNATURE <b>Read N. Calvert</b>		22b. ATTENDING M.D. PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	DATE SIGNED <b>4-15-67</b>
22c. PHYSICIAN'S NAME (Type) <b>READ N. CALVERT</b>		22d. ADDRESS <b>909 Pershing Drive Silver Spring</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal - Burial April 17, 1967</b>		23b. DATE THEREOF <b>Apr 17, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Greenlawn Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Columbus Ohio</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawlers</b> ADDRESS <b>1001 Washington D.C.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
By <b>J. E. Guttmann</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05448

## CERTIFICATE OF DEATH

05446

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b <i>DoA</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>	d. STREET ADDRESS <i>3945 Newdale Ln</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Office Belle Novak</i>	First <i>Office</i>	Middle <i>Belle</i>	Last <i>Novak</i>
4. DATE OF DEATH <i>April 19 1967</i>	Month <i>April</i>	Doy <i>19</i>	Year <i>1967</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH <i>July 13 1891</i>
9. AGE (In years lost birthday) <i>75 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Clothes yes</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Clayton Georgia</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Augustus Swofford</i>	14. MOTHER'S MAIDEN NAME <i>Ella Duncan</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>272-10-07753</i>	17. INFORMANT Husband <i>Thomas F. Novak</i>	Address <i>Same as Item 2.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Infarction</i> DUE TO <i>Arteriosclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Diabetes mellitus</i>		DUE TO <i>10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Diabetes mellitus</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) <i>Hyattsville</i>		(County) <i>Maryland</i>	
(State) <i>MD</i>			
21. I certify that (I) ( <i>this hospital</i> ) attended the deceased from <i>November 1958</i> , to <i>4/19 1967</i> , that (I) ( <i>we</i> ) lost saw the deceased alive on <i>4/16 1967</i> , and that death occurred at <i>10:52 AM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>4/19/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>J. BLAINE FITZGERALD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS <i>8218 Wisconsin Ave. Bethesda, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>4-22-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>George Wash. Cemetery</i>	23d. LOCATION (City or Town) <i>Hyattsville, Maryland</i>
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS <i>Robert A. PUMPHREY, Bethesda, Maryland</i>	25a. REC'D BY REGISTRAR <i>APR 24 1967</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

84120

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)										
MONTGOMERY			a. STATE Md.										
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING			b. COUNTY Montgomery										
c. LENGTH OF STAY IN 1b 18 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FAIRLAND NURSING HOME			d. STREET ADDRESS 10600 MONTROSE AVE										
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) GLADYS			First	Middle	Last	4. DATE OF DEATH 4 - 13 1967	Month	Day	Year				
5. SEX F			6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/99	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months	Days	Hours	11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.N.			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) WASH. D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME FRANK FEILD			14. MOTHER'S MAIDEN NAME MARGARET JACOBS			Address Same as Item 2.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 214-33-9556-A			17. INFORMANT Daughter Jane O'Donnell			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> DUE TO (b) <i>Hypertensive Cardiovascular Disease</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH	
Cconditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. 443X													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Urinary Tract infection</i>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) Arlington, Virginia			(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <i>March 30, 1967</i> to <i>April 13, 1967</i> , that (I) (we) last saw the deceased alive on <i>April 9, 1967</i> , and that death occurred at <i>1019 University Boulevard, East</i> , M, from the causes and on the date stated above.									22b. DATE SIGNED <i>April 13, 1967</i>				
22a. SIGNATURE <i>Boris Rubkin</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS Silver Spring, Md. 1019 University Boulevard, East							
22c. PHYSICIAN'S NAME (Type) Boris Rubkin													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4-18-67			23c. NAME OF CEMETERY OR CREMATORIAL Arlington Natl Cem.			23d. LOCATION (City, town or county) Arlington, Virginia			(State)	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland			ADDRESS			25a. REC'D BY REGISTRAR APR 17 1967			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
VR A15 (4) 20M 1/65													



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>D.C.</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 16 <i>5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		d. STREET ADDRESS <i>6001 Broadbranch Road</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Grace R. Ostrich</i>		First	Middle	Last	4. DATE OF DEATH Month <i>4</i>	Month <i>10</i>	Day Year <i>19 1967</i>
S. SEX <i>F.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 15 1887</i>	9. AGE (In years last birthday) <i>79 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days Hours Min. <i>0 0 0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Educator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>ACE</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Brooklyn N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Lewis W Reilly</i>		14. MOTHER'S MAIDEN NAME <i>Rose Clare Mapes</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-48-995</i>		17. INFORMANT <i>William L Kessel</i>		Address <i>5410 Brundrett Ave. Wash. D.C.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>4330</i>		Cardiac arrest				INTERVAL BETWEEN ONSET AND DEATH <i>several</i>	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last <i></i>		DUE TO (b)	Chronic congestive heart failure		3 yrs		
		DUE TO (c)	Myocarditis + valvular heart disease		20+yr		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1967</i> , to <i>10 Apr 1967</i> , that (I) (was) last saw the deceased alive on <i>10 Apr 1967</i> , and that death occurred at <i>10:53 PM</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>Herbert Martyn Jr</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>10 Apr 67</i>	
22c. PHYSICIAN'S NAME (Type) <i>HERBERT MARTYN JR</i>		22d. ADDRESS <i>4740 Chevy Chase Dr. Ch. Ch. Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/14/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>New Cathedral</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md.</i>	
24. FUNERAL DIRECTOR <i>Jas. T. Ryan, Inc.</i>						25a. REC'D BY REGISTRAR <i>APR 14 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Ryan</i>

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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05451

## CERTIFICATE OF DEATH

05449

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>8201 16th st.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bethesda Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Samuel</i>		First <i>S</i>	Middle <i>A</i>	Last <i>Ostrow</i>	4. DATE OF DEATH Month <i>APRIL</i>	Day <i>12</i>	Year <i>1967</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>11/30/95</i>	9. AGE (In years last birthday) <i>71</i> yrs.	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Purchasing</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Bridgeport, Conn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Abraham G. Ostrow</i>		14. MOTHER'S MAIDEN NAME <i>Sadie M. Mazur</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>554-16-8607</i>		17. INFORMANT <i>Allan M. Ostrow (son)</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA OF lung &amp; Generalized Metastases</i>						INTERVAL BETWEEN ONSET AND DEATH <i>6 days.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>103X</i>		DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>OCTOBER</i> , 19 <i>66</i> , to <i>APRIL 12</i> , 19 <i>67</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>4/10</i> , 19 <i>67</i> , and that death occurred at <i>4:30 A.M.</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>William S. Miller</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>William S. Miller M.D.</i>		22d. ADDRESS <i>4201-Conn Ave. N.W. D.C.</i>		22e. DATE SIGNED <i>4/12/67</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>4/12/67</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Lee's Crematorium</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>	
24. FUNERAL DIRECTOR <i>Lee Funeral Home</i>		ADDRESS <i>Washington, D.C.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 14 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT

05452

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05450

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
<i>Montgomery Maryland</i>		<i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
<i>Bethesda Md.</i>		<i>15 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Surburban</i>		<i>Bethesda</i>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Virginia Thorpe</i>		<i>Oz</i>	<i>jeep</i>
4. DATE OF DEATH	Month	Day	Year
<i>April 17</i>	<i>1967</i>		
5. SEX	6. COLOR OR RACE	7. MARRIED WOMOED	NEVER MARRIED DIVORCED
<i>Female white</i>		<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
<i>2/27/14</i>	<i>53 yrs.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>real estate saleswoman</i>		<i>Retail</i>	
10c. OCCUPATION (If different from above)		11. BIRTHPLACE (State or foreign country)	
		<i>Kentucky</i>	
12. CITIZEN OF WHAT COUNTRY?		<i>U. S. A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>William Thorpe</i>		<i>Eva Ginger Gause</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>400-24-8733</i>	
17. INFORMANT		<i>Tanice Keys</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Cardiac Tamponade - Massive -</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		<i>3 min.</i>	
(b) DUE TO		<i>Rupture of Heart -</i>	
(c) DUE TO		<i>Auto Accident.</i>	
3 hr.		3 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
		<i>Driving car on left Side of Road crashed into oncoming</i>	
20c. TIME OF INJURY Month, Day, Year <i>5:55 p.m. 4/17 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Street.</i>
		20f. (City or town) (County) (State)	<i>Bethesda Mont. Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <i>Bethesda, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-20-67</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>St. Paul's Cemetery</i>
23d. LOCATION (City or Town) (County) (State) <i>Laytonsville, Maryland</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADORESS	25a. REC'D BY REGISTRAR <i>APR 24 1967</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**4**  
**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05453

CERTIFICATE OF DEATH

05451

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Md.</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanatorium &amp; Hosp.</i>		d. STREET ADDRESS <i>212 Hannes Drive</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Josephine</i>	Middle <i>None</i>	Last <i>Pappatardo</i>
4. DATE OF DEATH	Month <i>4</i>	Doy <i>26</i>	Year <i>1967</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVDRCED <input type="checkbox"/>
8. BIRTH DATE OF DEATH <i>March 9, 1877</i>		9. AGE (In years last birthday) <i>90 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TAILRESS - RETIRED</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>TAILORING</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>ITALY</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>	
13. FATHER'S NAME <i>Antonio Bonanno</i>		14. MOTHER'S MAIDEN NAME <i>Vera Borzi</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-14-1703</i>	
17. INFORMANT <i>Mrs. Santina Miller, (same as #2.)</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4221</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs</i>	
IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerotic cardiovascular disease</i>			
(b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Silver Spring</i> (County) <i>Prince Geo. Co.</i> (State) <i>Maryland</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 2</i> , 1967, to <i>April 26</i> , 1967, that (I) (we) last saw the deceased alive on <i>April 26, 1967</i> , and that death occurred at <i>5:10 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Raymond Bradshaw, Jr.</i>			
22c. PHYSICIAN'S NAME (Type) <i>RAYMOND BRADSHAW, JR.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED <i>April 26, 1967</i>	
22d. ADDRESS <i>345 University Blvd, Silver Spring</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 1, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City or Town) <i>Prince Geo. Co.</i> (County) <i>Maryland</i> (State)	
24. FUNERAL DIRECTOR <i>Arthur W. Jackson</i>		25a. ADDRESS <i>254 Carroll St. 81.01</i>	
25b. REG'D BY REGISTRAR <i>Charles J. Judge</i>		25c. DATE <i>MAY 1 1967</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05454

CERTIFICATE OF DEATH

05452

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Amherst</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Amherst</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>				d. STREET ADDRESS <b>Box 178</b>							
3. NAME OF DECEASED (Type or print) <b>James</b>		First	Middle <b>Edward</b>	Lost	4. DATE OF DEATH <b>Pendleton</b>	Month <b>April</b>	Day <b>30</b>	Year <b>19 67</b>			
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>February 7, 1917</b>	9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months <b>50</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pantry worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>College</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>James L. Pendleton</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Gilmore</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1943-1945</b>		16. SOCIAL SECURITY NO. <b>208-20-0703</b>		17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda, Md. 20014</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cor pulmonale, Respiratory Failure				INTERVAL BETWEEN ONSET AND DEATH <b>2 Hrs.</b>					
20411 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO (b) Generalized Bronchospasm				4 Days					
		DUE TO Chronic Myelogenous Leukemia				1½ Yrs.					
		(c) in Blastic Crisis				1½ Wk.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>(1) Renal Failure, (2) Gastrointestinal Hemorrhage.</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>XIX</b> (this hospital) attended the deceased from <b>April 27, 1967</b> , to <b>April 30, 1967</b> , that <b>XIX</b> (we) last saw the deceased alive on <b>April 30, 1967</b> , and that death occurred at <b>6:25 PM</b> , from causes and on the date stated above.											
22a. SIGNATURE <b>I. David Goldman, M. D.</b>				ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		DATE SIGNED <b>May 1, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>I. David Goldman, M. D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>5/1/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Amherst, Va.</b>		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>		ADDRESS <b>Rockville, Md</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

OP22

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• 1) *Experiments* *with* *the* *ability* *of* *eliciting* *responses* *in* *laboratory* *subjects* *by* *medication*

**To HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

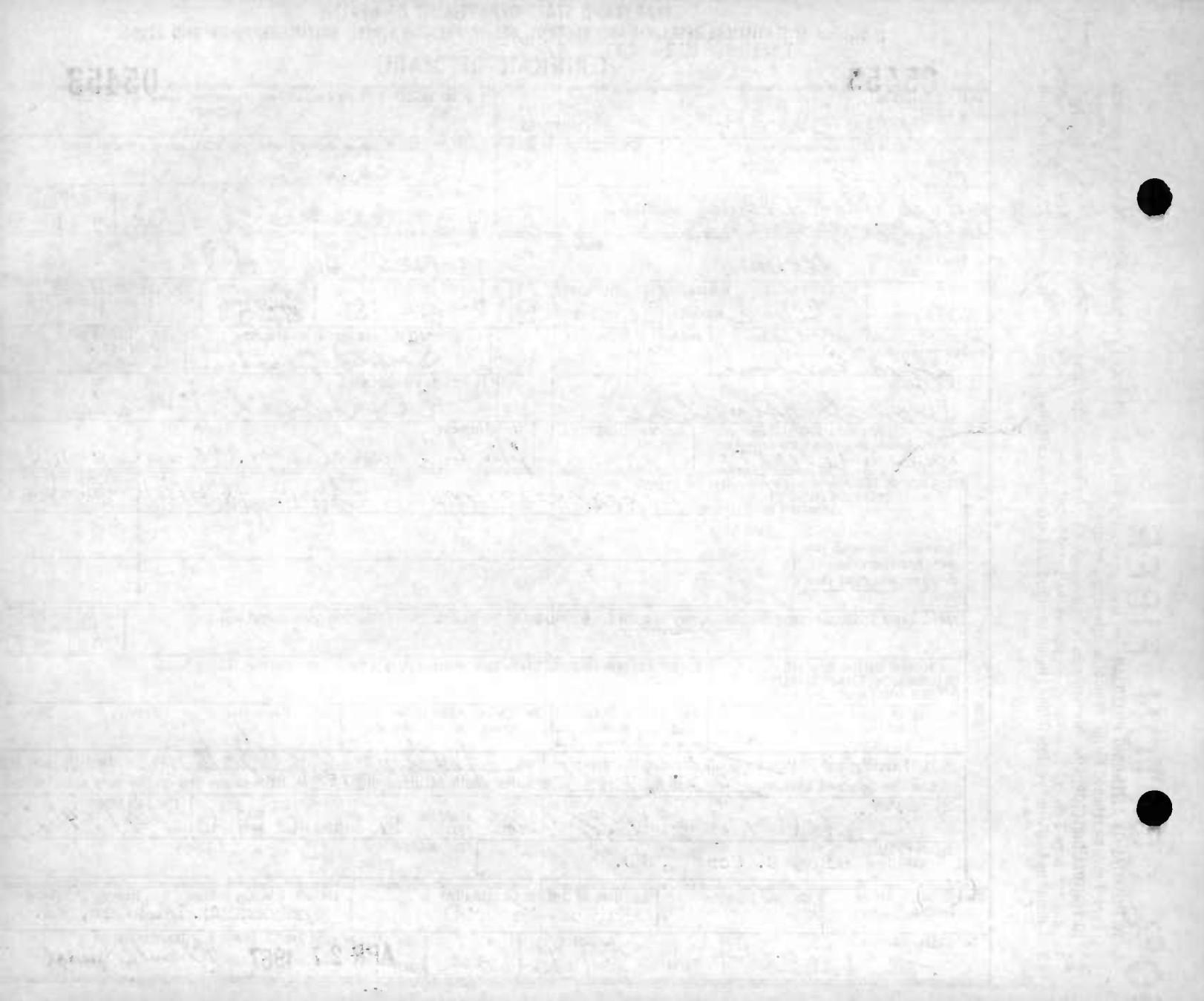
**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #9 Film #G388 5/8/67 pg. 05453

**CERTIFICATE OF DEATH**

05453

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>MARYLAND</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>POTOMAC VALLEY NURSING HOME 1235 POTOMAC VALLEY RD.</b>			d. STREET ADDRESS <b>431 Oneida Pl. n.w.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>VERNON</b>		First	Middle	Last	4. DATE OF DEATH <b>PEOPLES</b>	Month <b>4</b>	Doy <b>24</b>	Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-4-15</b>	9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months <b>52</b>	IF UNDER 24 HRS. Days <b>51</b>	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Post Employee</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Donald Peoples</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Charles</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WWII</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Pauline White 431 Oneida Pl. n.w.</b>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1930</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			<i>Cervical carcinoma, Brain metastasis</i>						INTERVAL BETWEEN ONSET AND DEATH <b>10 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>3/14/67</b> , 19 to <b>4/23/67</b> , 19, that (I) (we) last saw the deceased alive on <b>4/23/67</b> , 19, and that death occurred at <b>3:15A.M.</b> from causes and on the date stated above.									22b. DATE SIGNED <b>4/24/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Henry C. Scruggs, MD.</b>			22d. ADDRESS						
23a. BURIAL/CREMATION, REMOVAL (Specify) <b>4/29/67</b>			23b. DATE THEREOF <b>4/29/67</b>		23c. NAME OF CEMETERY OR CREMATORIALy <b>Harmony Memorial</b>			23d. LOCATION (City or Town) (County) (State) <b>Harmonyst. Lander, Md.</b>	
24. FUNERAL DIRECTOR <b>Fragile 4/21 389 Rockville</b>			ADDRESS <b>389 Rockville</b>			25a. REC'D. BY REGISTRAR DATE <b>APR 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

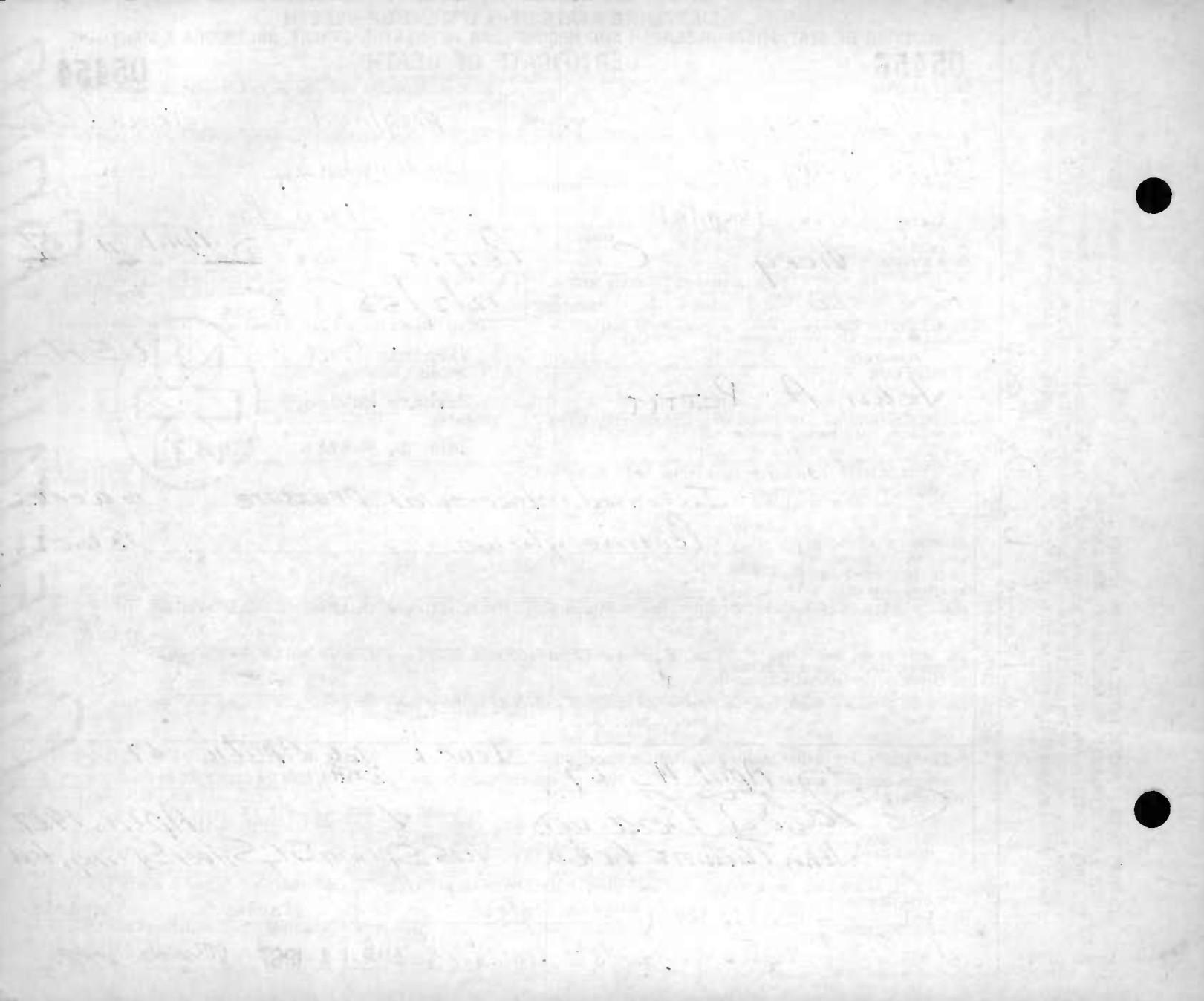
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**05456**

**CERTIFICATE OF DEATH**

**05454**

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring Md.</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bladensburg</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Holy Cross Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Vicky</i>		First <i>C</i>	Middle <i>Pettit</i>
4. DATE OF DEATH Month <i>April</i>	Day <i>11</i>	Year <i>57</i>	5. SEX <i>F</i>
6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/2/58</i>	9. AGE (In years last birthday) <i>8 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>minor</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Virginia (Page Co.)</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John A. Pettit</i>	14. MOTHER'S MAIDEN NAME <i>Barbara McCleary</i>	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY ND.	17. INFORMANT <i>John A. Pettit (Item 2)</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Increased intracranial pressure</i> DUE TO (b) <i>Pontine glioma</i> DUE TO (c)
			INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1, 1966</i> , to <i>April 11, 1967</i> , that (I) (we) last saw the deceased alive on <i>April 14, 1967</i> , and that death occurred at <i>8:25 AM</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>April 11, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>John Thomas bold</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. 22d. ADDRESS <i>1015 Spring St, Silver Spring, Md.</i>	23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>
23b. DATE THEREOF <i>Apr. 13, '67</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Graves Chapel</i>	23d. LOCATION (City, town or county) (State) <i>Stanley Virginia</i>
24. FUNERAL DIRECTOR ADDRESS <i>L. H. Lester &amp; Sons Chuck Jr.</i>		25a. REC'D BY REGISTRAR <i>APR 14 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05457

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05455

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>2<sup>1</sup>/hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>42 Evergreen Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Richard</b>		First	Middle	Last	4. DATE OF DEATH <b>4-14-67</b>	Month	Day	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8-1-49</b>	9. AGE (In years birthday) <b>19</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>		11. BIRTHPLACE (State or foreign country) <b>London, England</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Richard J. Phelps</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Boone</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Bernard Butler</b>		Address <b>Above</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination - from Rupture of Rt lung</b>		DUE TO <b>8234</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 1/4 m.</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>lost.</b>		(b) <b>Trauma from Auto Accident.</b>						
DUE TO <b>8:45 p.m.</b>		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger micro - that ran off road and struck a pole -</b>						
20c. TIME OF INJURY Month, Day, Year <b>Hour 8:45 p.m. 4/13 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg, etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>R. Clarksville Howard MD</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>John S. Bell</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>4/14/67</b>		
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Funeral Home</b>		23b. DATE THEREOF <b>4-17-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Elk Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Calmair Manor Md</b>		
24. FUNERAL DIRECTOR <b>John S. Bell</b>		ADDRESS <b>General Hospital</b>		25a. REC'D BY REGISTRAR <b>APR 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
VR A15ME (5) 6M 1/66								

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and a lot

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05458		CERTIFICATE OF DEATH						05456			
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN lb			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>			d. STREET ADDRESS <b>2110 DEXTER AVE.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>FANNIE</b>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/10/88</b>	9. AGE (In years last birthday) <b>79 yrs.</b>	10. IF UNDER 1 YEAR <b>Months</b>	11. IF UNDER 24 HRS <b>Days</b>	12. IF UNDER 24 HRS <b>Hours</b>	13. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>			11. BIRTHPLACE (County & State, or foreign country) <b>AUSTRIA</b>					
13. FATHER'S NAME <b>Abraham Silber</b>			14. MOTHER'S MAIDEN NAME <b>Anna ? ? ?</b>			15. ADDRESS <b>8523 Freymann Drive Chevy Chase, Maryland</b>					
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Pearle Miller</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral anoxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. <b>170X</b>			INTERVAL BETWEEN ONSET AND DEATH		
(b) <b>Cerebral metastasis</b> DUE TO			(c) <b>Carcinoma breast</b>			2 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>(County)</b> <b>(State)</b>				
21. I certify that (I) (this hospital) attended the deceased from <b>now</b> <b>7</b> , 19 <b>66</b> , to <b>August 22</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Aug 21</b> , 19 <b>67</b> , and that death occurred at <b>10:28 A.M.</b> , from causes and on the date stated above.									22d. DATE SIGNED <b>4-22-67</b>		
22a. SIGNATURE <b>Edward J. Richards</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. ADDRESS <b>10110 Ga. Ave., Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4-23-1967</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Agudath Achim Cemetery</b>			23d. LOCATION (City or Town) <b>Lorain County, Ohio</b> (County) (State)		
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b> ADDRESS <b>4217 9th St., N.W.</b>						25a. REC'D BY REGISTRAR <b>APR 24 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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Aug 20 1970

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Ward

Signed

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1972/11

FOR STATE  
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute one certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05459

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05457

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 15 <sup>1/2</sup> years		a. STATE Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) XXXX 211 Springbrook Drive				b. COUNTY Montgomery	
3. NAME OF DECEASED (Type or print)		First Mary	Middle Baris	Last Pilgrim	4. DATE OF DEATH April 21 1967
5. SEX Fe	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-1908	9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Martins Ferry, Ohio	
13. FATHER'S NAME Thomas H. Baris		14. MOTHER'S MAIDEN NAME Lucy Sedgwick		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 212-32-1594		17. INFORMANT Dennis C. Pilgrim Address 10020 Brookmoor Drive Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET, AND DEATH Few minutes			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 9160		DUE TO (b) Smoke inhalation Few minutes			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary edema		INTERVAL BETWEEN ONSET, AND DEATH Few minutes			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Found in her burned out bedroom			
20c. TIME OF INJURY Month, Day, Year Hour am. 4 21 1967 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Silver Spring Mont Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John S. Rogers, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John S. Rogers, M.D. 1919 Seminary Rd., Silver Spring, Md.			
EXAMINER'S NAME (Type)		22. DATE SIGNED 4-21-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr 26, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery	
24. FUNERAL DIRECTOR John B. Thomas, 8434 Georgia Avenue Warren E. Pumphrey, Inc. Silver Spring, Md.		ADDRESS		23d. LOCATION (City, town or county) Rockville, Maryland	
				25a. REC'D BY REGISTRAR APR 27 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



05460

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Cleared by  
Mail 1/20/67

05458

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12504 Farnell Drive		d. STREET ADDRESS 12504 Farnell Drive							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Theodore K. Piotrowski		First	Middle						
4. DATE OF DEATH April 27, 1967	Month	Doy	Year						
5. SEX Male White		6. COLOR OR RACE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH July 16, 1910	9. AGE (In years lost birthday) 56 yrs.	10. IF UNDER 1 YEAR Months 9 Days 11 Hours 11 Min.	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Gladys A. Piotrowski - wife - same item		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) DUE TO (c)		Congestive Heart Failure  Hypertensive arterosclerotic heart disease, 2 years		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diphtheria						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that (I) (the hospital) attended the deceased from <u>3/25</u> , 1967, to <u>April 27, 1967</u> that (I) (he) last saw the deceased alive on <u>April 25, 1967</u> , and that death occurred at <u>8:50 AM</u> , from causes and on the date stated above.									
22o. SIGNATURE Michael R. Dobridge		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 27, 1967					
22c. PHYSICIAN'S NAME (Type) Michael R. Dobridge		22d. ADDRESS 12600 Parkland Drive, Rockville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/1/67		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		23d. LOCATION (City or Town) Silver Spring, Montg. Md.		(County) (State)	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1331 Rockville Rockville,		25a. REC'D BY REGISTRAR P. MAY 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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05459

FOR STATE  
HEALTH DEPT.

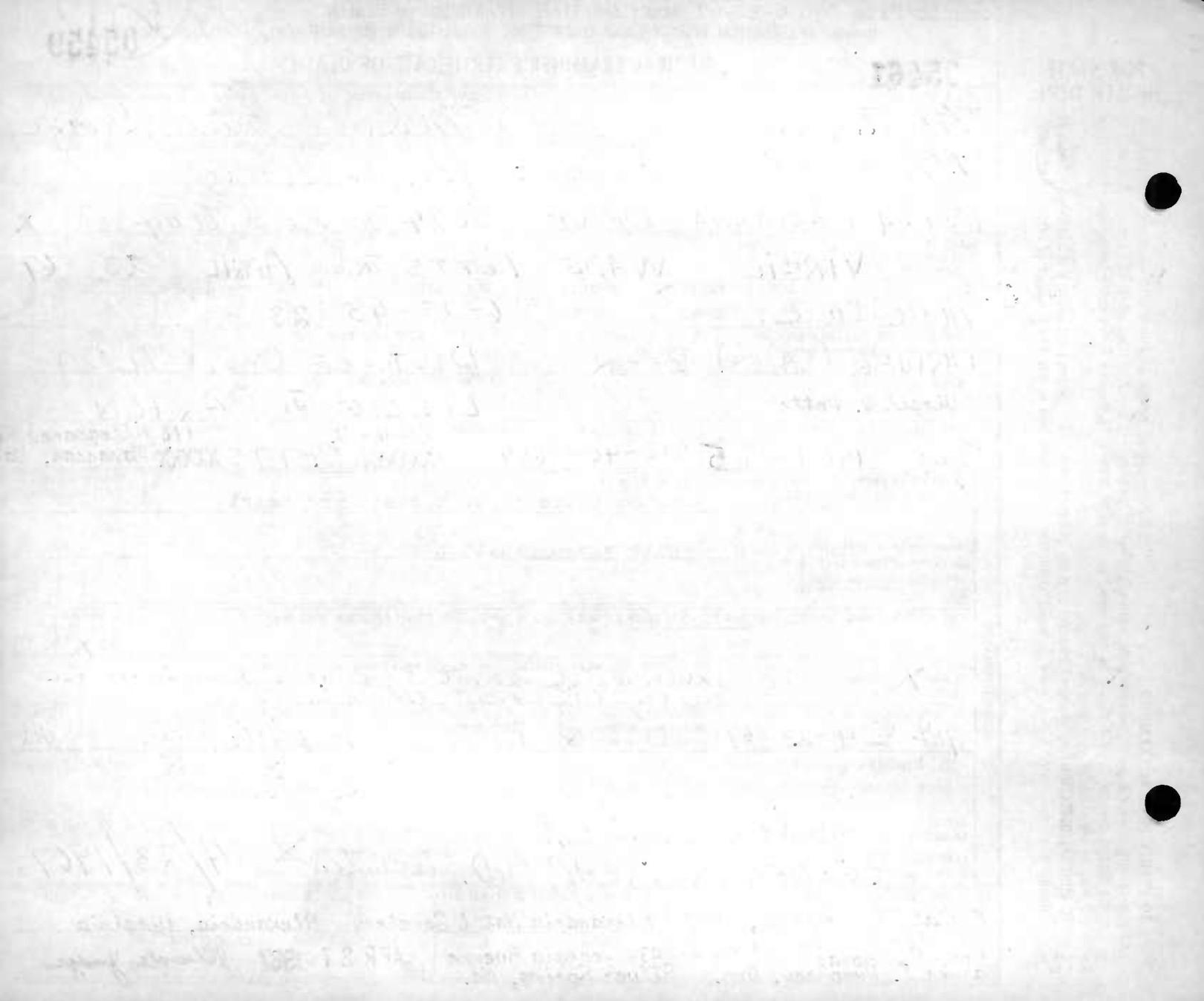
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours of death.

05461

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
<i>Montgomery</i> <i>Rockville</i>		<i>Maryland</i> <i>Md., Prince George</i>	
c. LENGTH OF STAY IN lb <i>Four minutes</i>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bladensburg</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>13924 MARIANNA DRIVE</i>		e. STREET ADDRESS <i>5024 Townsend Way</i>	
3. NAME OF DECEASED (Type or print)		First <i>VIRGIL</i>	Middle <i>WADE</i>
3. NAME OF DECEASED (Type or print)		Lost <i>POTTS, JR.</i>	4. DATE OF DEATH Month <i>APRIL</i>
5. SEX <i>Male</i>		5. COLOR OR RACE <i>Cauc.</i>	6. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DRIVER (SALES)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Beer</i>	
11. BIRTHPLACE (State or foreign country) <i>DIST. OF COL.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Virgil W. Potts</i>		14. MOTHER'S MAIDEN NAME <i>LIZZIE J. BARTON</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>1962-1965 213-40-9694</i>	
17. INFORMANT <i>Esther V. Potts</i>		18. INTERVAL BETWEEN ONSET AND DEATH <i>Address 118 Alleghany Rd Manassas, Va</i>	
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Decesased shot by licensee whom he allegedly had threatened.</i>	
20c. TIME OF INJURY Month, Day, Year <i>914 4-23 1967</i>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <i>4/23/1967</i>	
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Alexandria, Virginia</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr 28, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Alexandria Nat'l Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Alexandria, Virginia</i>	
24. FUNERAL DIRECTOR <i>John B. Thomas</i>		25a. REC'D BY REGISTRAR DATE <i>APR 27 1967</i>	
24. FUNERAL DIRECTOR <i>Warren E. Humphrey, Inc.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

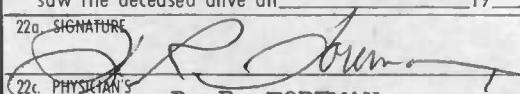
05462

CERTIFICATE OF DEATH

05460

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(RURAL) BETHESDA</b>		c. LENGTH OF STAY IN lb <b>5 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. NAVAL HOSPITAL, BETHESDA, MD.</b>		e. STREET ADDRESS <b>ARMY DISTAFF HALL</b>	
3. NAME OF DECEASED (Type or print) <b>KATHERINE</b>		First <b>KATHERINE</b>	Middle <b></b>
Last <b></b>		4. DATE OF DEATH <b>APRIL 26 1967</b>	Month Day Year
S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUC.</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>JAN 31, 1885</b>		9. AGE (In years at birthday) <b>82 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>ST. JOSEPH, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT W. DOWDY</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE CLARKSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>229 60 0334</b>	
17. INFORMANT <b>NAVY RECORDS</b>		Address <b>USNH BETHESDA, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSIVE, ARTERIOSCHLEROTIC CARDIOVASCULAR</b>			
443 X DUE TO <b>DISEASE</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ stating the underlying cause (c) _____			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town) <b></b> (County) <b></b> (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>APRIL 27, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. R. FOREMAN</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMAINS AT <b>BURIAL</b>		23b. DATE THEREOF <b>5-1-67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>ARLINGTON NAT. CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA</b>	
24. FUNERAL DIRECTOR <b>R.A. PUMPHREY 7557 WISCONSIN AVE. BETH. MD.</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>DATE</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Juges</b>

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**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**11 TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If gas and 2 other deaths should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours of death.

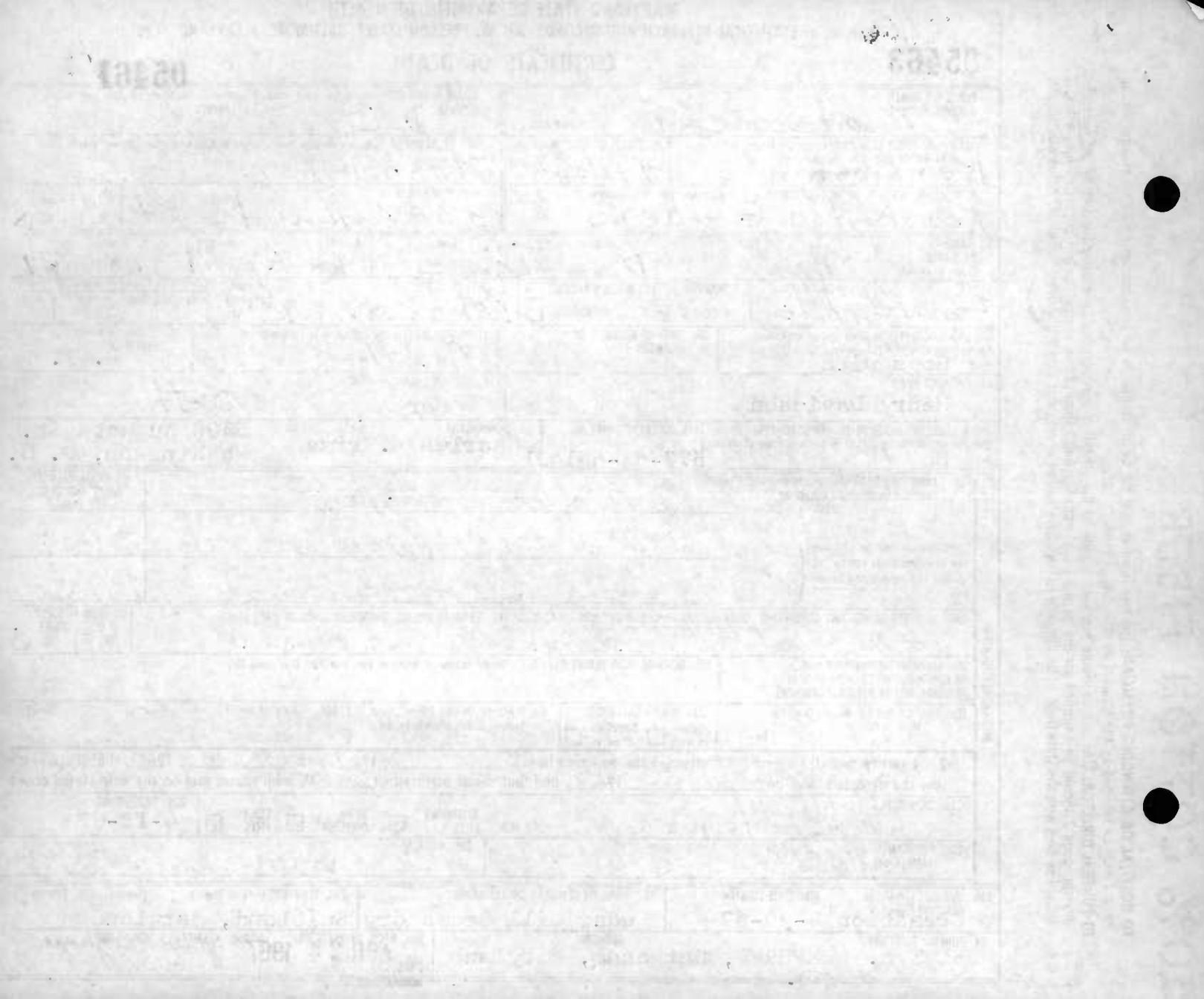
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05463

## CERTIFICATE OF DEATH

05461

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C. Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN lb <b>18 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kensington Gardens</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ANNA</b>	Middle <b>D.</b>	Last <b>Prime</b>		
4. DATE OF DEATH	Month <b>April</b>	Day <b>18</b>	Year <b>1967</b>		
5. SEX <b>Female</b>	6. COLOR OF RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 25 1877</b>		
9. AGE (In years last birthday) <b>90 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Henry Davidson</b>	14. MOTHER'S MAIDEN NAME <b>Mary Seath</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>577-68-6314J1</b>	17. INFORMANT <b>Son</b> <b>Charles R. Prime</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO <b>HYPOSTATIC PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPOSTATIC PNEUMONIA</b> DUE TO (c) <b>CEREBROVASCULAR ARTERIOSCLEROSIS</b>	19. INTERVAL BETWEEN ONSET AND DEATH <b>10 MINUTS</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized arteriosclerosis. Old hip fracture.</b>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fracture of right femur.</b>	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Bethesda</b> (County) <b>Montgomery</b> (State) <b>Md.</b>		
21. I certify that (I) (This hospital) attended the deceased from <b>JULY</b> , 19 <b>67</b> , to <b>APRIL 18</b> , 19 <b>67</b> , that (I) (We) last saw the deceased alive on <b>April 6</b> , 19 <b>67</b> , and that death occurred at <b>3:30 PM</b> , from causes and on the date stated above.	22a. SIGNATURE <b>Joseph D. Connor</b>	M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4-18-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH D. CONNOR, MD</b>	22d. ADDRESS <b>9420 Over Georgetown Rd Bethesda, Md.</b>	23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>4-20-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Crematory</b>	23d. LOCATION (City or Town) <b>Suitland, Maryland</b> (County) <b>Maryland</b> (State)
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>	ADDRESS <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>	25a. REC'D BY REGISTRAR <b>APR 24 1967</b>	25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	DATE	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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05466

CERTIFICATE OF DEATH

05462

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		d. STREET ADDRESS <b>5132 White Rock Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANITARIUM + HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>STANLEY</b>		First <b>MOODY</b>	Middle <b>PRYOR</b>
4. DATE OF DEATH Month <b>APRIL</b>		Lost <b>9</b>	Doy Year <b>1967</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WH</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/17/79</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STONE MASON</b>		11. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>SAMUEL PRYOR</b>	
14. MOTHER'S MAIDEN NAME <b>Louise Cline</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORDS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteria terminalis</b> DUE TO <b>200X</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ASHD c congestive heart failure</b> DUE TO <b>2 years</b> (c) <b>Diabetes mellitus</b> DUE TO <b>3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) <b>Hyattsville</b> (County) <b>Md.</b> (State) <b>MD.</b>
21. I certify that (I) (This hospital) attended the deceased from <b>4/3</b> , 1967, to <b>4/9</b> , 1967, that (I) (we) last saw the deceased alive on <b>4/9</b> , 1967, and that death occurred at <b>5:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>4/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Hugh Trey</b>		22d. ADDRESS <b>7105 - RIGGS RD, HYATTSVILLE MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-12-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Bethel Church of God</b>
24. FUNERAL DIRECTOR <b>Raymond E. O'Leary</b>		E. ADDRESS <b>Thomaston, Md.</b>	25a. REC'D BY REGISTRAR <b>APR 13 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

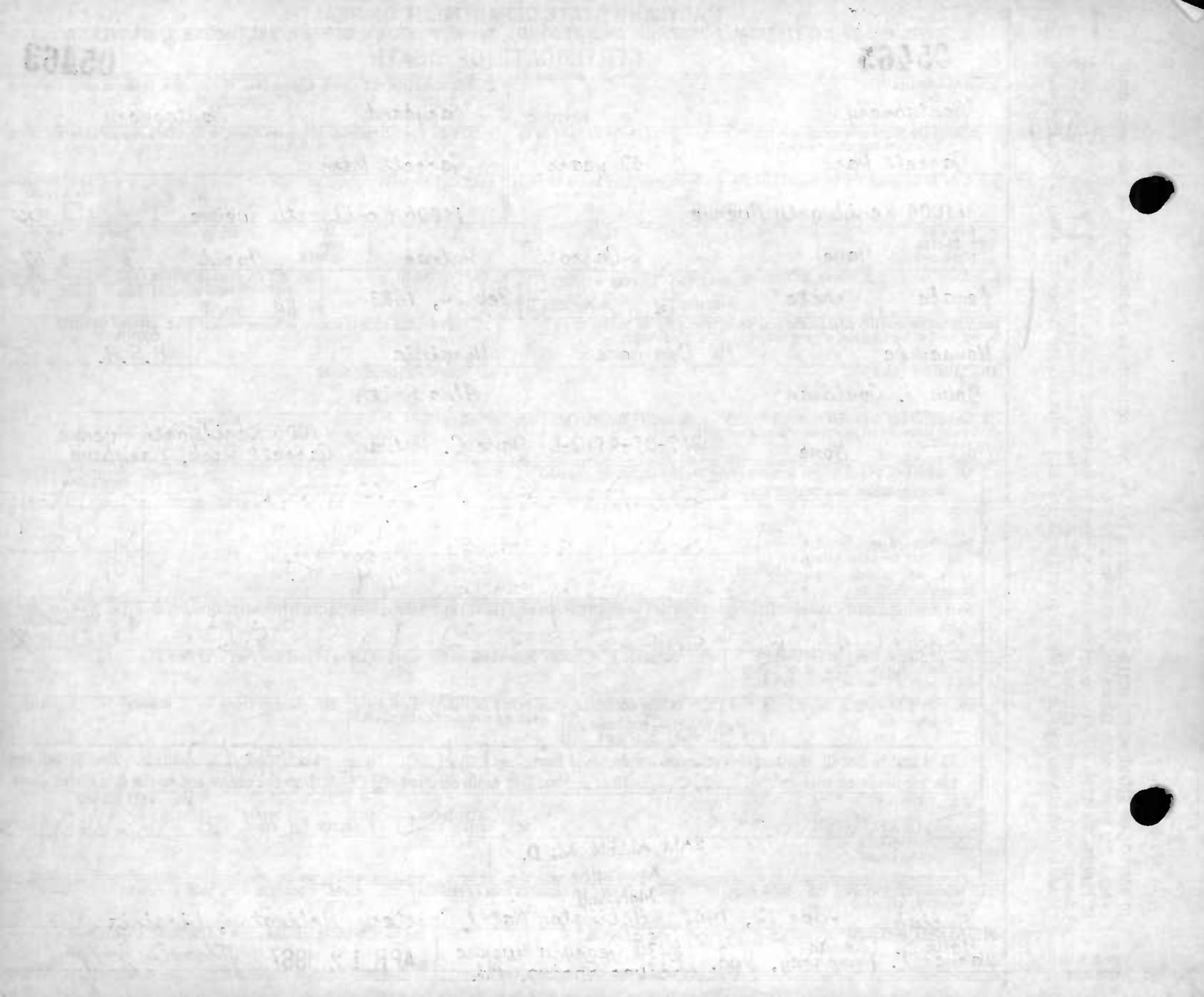
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05463

CERTIFICATE OF DEATH

05463

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrett Park</i>		c. LENGTH OF STAY IN 1b <i>62 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrett Park</i>		151	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>11006 Kenilworth Avenue</i>		d. STREET ADDRESS <i>11006 Kenilworth Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Jane</i>	Middle <i>Carroll</i>	Last <i>Putnam</i>	4. DATE OF DEATH <i>April 8 1967</i>	Month <i>April</i>	Day <i>8</i>	Year <i>1967</i>
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 24, 1883</i>	9. AGE (In years last birthday) <i>84 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John J. Gouldman</i>		14. MOTHER'S MAIDEN NAME <i>Alma Smith</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <i>No None</i>	17. INFORMANT <i>Jane C. Putnam</i>	Address <i>11006 Kenilworth Avenue Garrett Park, Maryland</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4500</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		Songtive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH <i>2-3 days</i>			
(b) <i>Intercalicular Hemizyg.</i>		Severity - age 84		yrs		yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carcinoma - Pancreatic &amp; Liver Metastasis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i></i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <i></i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>		
21. I certify that (I) (this hospital) attended the deceased from <i>3/7/67</i> to <i>4/8/67</i> , 19, that (I) (we) last saw the deceased alive on <i>4/7/67</i> 19, and that death occurred at <i>245</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Samuel Allen</i>		22b. DATE SIGNED <i>4/8/67</i>					
22c. PHYSICIAN'S NAME (Type) <i>SAM ALLEN, M. D.</i>	22d. ADDRESS <i>Kensington</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Apr 12, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Maryland</i>	23d. LOCATION (City, town or county) <i>Arlington Nat'l Cemetery Arlington, Virginia</i>	(State) <i></i>			
24. FUNERAL DIRECTOR <i>John B. Thomas John B. Thomas</i>	ADDRESS <i>8434 Georgia Avenue</i>	25a. REC'D BY REGISTRAR <i>APR 12 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
Warner E. Pumphrey, Inc.		Silver Spring, Md.	DAT				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05466

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05464

1. PLACE OF DEATH a. COUNTY <i>Mont.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seaford Del.</i>		c. LENGTH OF STAY IN 1b. <i>470.A.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburbans</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Raymond H. Rashid</i>		First <i>R</i>	Middle <i>A</i>
4. DATE OF DEATH <i>April 13 1967</i>		Last <i>H</i>	Year <i>1967</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>6/29/29</i>		9. AGE (In years last birthday) <i>37 yrs.</i>	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Registar</i>		11. BIRTHPLACE (State or foreign country) <i>Iowa</i>	
13. FATHER'S NAME <i>James J. Rashid</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes WWII</i>		16. SOCIAL SECURITY NO. <i>---</i>	
17. INFORMANT <i>Kenneth R. Rashid</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4343</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
		<i>Congestive Heart Failure - Acute - Pericarditis - old + Recent</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John S. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <i>4114/67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-17-1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cemetery</i>
23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i>		ADDRESS	
25a. REC'D BY REGISTRAR <i>APR 20 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE			
VR A15ME (5) 6M 1/67			

1

1933-1934 - 1935-1936 - 1936-1937 - 1937-1938

196

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05467

CERTIFICATE OF DEATH

05465

1. PLACE OF DEATH  
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Gaithersburg

c. LENGTH OF STAY IN lb

19Yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month  
Apr

Day  
27th

Year  
1967

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED

DIVORCED

Nov 23rd 1905

9. AGE (in years  
last birthday)  
61  
yrs.

10. IF UNDER 1 YEAR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Ret. Co., Rd. Emp.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Boyd. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

James A. Reid

14. MOTHER'S MAIDEN NAME

Debrah Burdette

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Md.

Richard S. Reid. Gaithersburg.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

DUE TO

(b)

DUE TO

(c)

Acute Coronary Thrombosis Minutes  
ARTERIOSCLEROTIC Years  
Heart Disease

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING

OP. CONTRIBUTING

CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.  
p.m.

19

20d. INJURY OCCURRED

While  
at work  Not While  
at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

4-28-67, 1967, to 4-28-67, that (I) (was) last

saw the deceased alive on 4-27-67, and that death occurred at P.M. from the causes and on the date stated above.

22a. SIGNATURE

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

22b. DATE  
SIGNED

4-28-67

22c. PHYSICIAN'S  
NAME (Type)

Jack Schumacher. Md.

22d. ADDRESS

Gaithersburg. Md.

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

23b. DATE THEREOF

5-1-67

23c. NAME OF CEMETERY OR CREMATORIAL

Presbyterian Ch.

23d. LOCATION (City, town or county)

Boyd's

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Ernest C. Gartner

ADDRESS

Gaithersburg. Md.

25a. REC'D. BY REGISTRAR

MAY 2

1967

25b. REC'D. BY JUDGE

Charles Judge

28200

HEAD TO STADIUM

28200

28200 28200 28200  
S.YAH

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

95468

CERTIFICATE OF DEATH

05466

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>12 days</u>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		b. COUNTY <u>Montgomery</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>71 Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>3304 Weller Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>John</u>	Middle <u>Henry</u>	Last <u>Rhine</u>	4. DATE OF DEATH April 13 1967	Month	Day	Year	
S. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>11-11-92</u>	9. AGE (In years lost birthday) <u>74 yrs.</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired printer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Govt. Printing Off.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>		
13. FATHER'S NAME <u>Joseph Rhine</u>			14. MOTHER'S MAIDEN NAME <u>Octavia Cronise</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <u>no</u> <u>None</u>			16. SOCIAL SECURITY NO. <u>220-44-0154</u>		17. INFORMANT <u>Hazel V. Rhine</u>		Address <u>3304 Weller Road Silver Spring, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the Pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) _____ DUE TO last (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1967</u> , to <u>April 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 12 1967</u> , and that death occurred at <u>12:30 AM</u> , from causes and on the date stated above.								22b. DATE SIGNED <u>4-13-67</u>	
22a. SIGNATURE <u>R. H. Sandstrom MD</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom MD</u>		22d. ADDRESS <u>7701 Carroll Ave Takoma Park, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 15, 1967 Rock Creek Cemetery</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>			
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		ADDRESS <u>1400 Rock Creek Parkway, 8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

22860

1980-10-21A9999

20180

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05469

**4**  
**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> o. COUNTY <i>Montgomery</i>		<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> o. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>18 days</i>	
c. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		d. STREET ADDRESS <i>7207 Maple Avenue</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium - Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <i>Mrs. Edyth</i>		First <i>haphemia</i>	Middle <i>Rice</i>
3. SEX <i>Female</i>		4. DATE OF DEATH Month <i>Apr.</i> Day <i>6</i> Year <i>1967</i>	Month <i>Apr.</i> Day <i>6</i> Year <i>1967</i>
5. COLOR OR RACE <i>white</i>		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVDRCED <input type="checkbox"/>	7. B. DATE OF BIRTH <i>10-21-91</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <i>75 yrs.</i>
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Harry Walter</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jones</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> ) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>Unknown</i>	17. INFORMANT <i>Records - Washington Sanitarium - Hospital</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertonic Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>18 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Thrombosis</i>			
DUE TO (c) <i>Thickened Myocarditis - Hypertensive Grade II</i>		18 days	
DUE TO		7½ Month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Thrombosis of Left Femoral Vein</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Thrombosis of Left Femoral Vein</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>9066 1/2</i>
20f. (City or town) <i>Washington</i>		(County) <i>D.C.</i> (State) <i>D.C.</i>	
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>10/5/1967</i> , and that death occurred at <i>9:30 AM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>10/6/67</i>	
22a. SIGNATURE <i>Howard T. Morse</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. 22b. ADDRESS <i>7030 Carroll Creek Takoma Park Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>April 10, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Prospect Hill Cemetery</i>
24. FUNERAL DIRECTOR <i>J. Arthur Walter, 254 Carroll St NW.</i>		ADDRESS <i>J. Arthur Walter, 254 Carroll St NW.</i>	24d. DATE <i>APR 10 1967</i>
			24e. REGISTRAR'S SIGNATURE <i>James J. Morse</i>

1940-20-200000

00150

70000

baseball

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

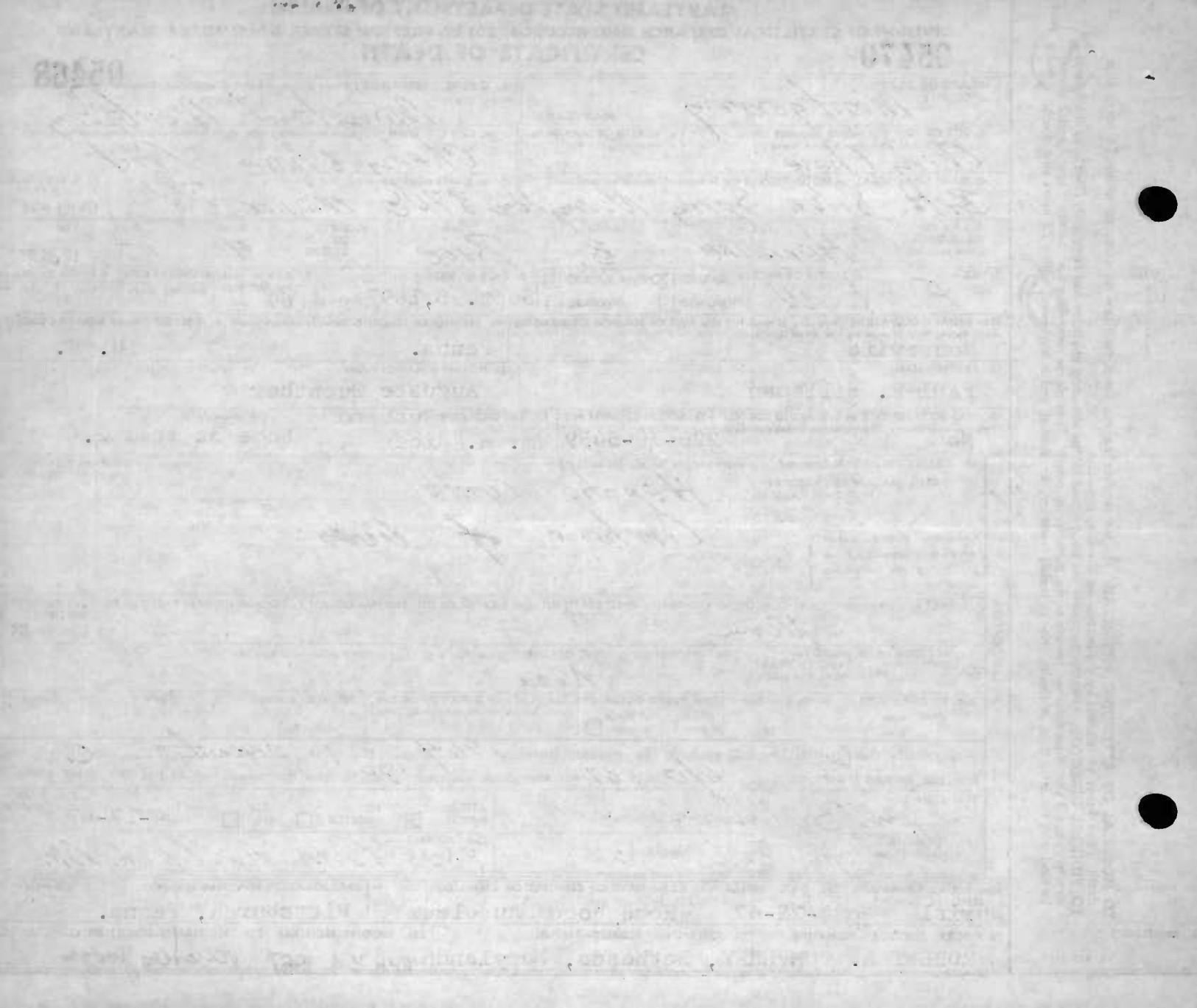
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

05468

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Beth. Silva Spring Nursing Home 3708 Marcella Rd.</i>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase Md.</i>	
3. NAME OF DECEASED (Type or print) <i>Hormine</i>		First <i>E.</i>	Middle <i>Rice</i>
4. DATE OF DEATH Month <i>4</i> Day <i>17</i> Year <i>1967</i>		5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <i>Sept. 8, 1897</i>		9. AGE (in years last birthday) <i>69 yrs.</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Paul R. Hilleman</i>		14. MOTHER'S MAIDEN NAME <i>Auguste Guenther</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-50-5459</i>	
17. INFORMANT <i>Husband</i>		Address <i>Same as Item 2.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic coma</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Cirrhosis of liver</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <i>1964</i> , 19, to <i>present</i> , 19, that (1) (we) last saw the deceased alive on <i>4/17</i> , 1967, and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <i>John B. Umhao</i>		22b. DATE SIGNED <i>4-17-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOHN B. UMHAO</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-22-67</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Home Wood Mausoleum</i>		23d. LOCATION (City, town or county) (State) <i>Pittsburgh, Penna.</i>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS	
25a. REC'D BY REGISTRAR <i>APR 24 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05471

CERTIFICATE OF DEATH

05469

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
Montgomery MARYLAND		Bethesda		20 days		a. STATE Tennessee b. COUNTY					
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
						Louisville 793					
						d. STREET ADDRESS					
						Route # 1					
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Lillian	Middle Leona	Last Richardson	4. DATE OF DEATH	Month April	Day 10	Year 19 67			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS			
Female		White			January 23, 1923	44 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most al working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Not employed			11. BIRTHPLACE (County & State, or foreign country) Tennessee			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Azer Lane			14. MOTHER'S MAIDEN NAME Victoria Moore								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 412-30-8426			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland 20014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Progressive pulmonary consolidation</u> DUE TO <u>171X</u>									INTERVAL BETWEEN ONSET AND DEATH 3 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive blood transfusion &amp; hemolysis</u> DUE TO (c) <u>Carcinoma of Cervix</u>									7 days 12 Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 21</u> , 19 <u>67</u> , to <u>April 10</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 10</u> , 19 <u>67</u> , and that death occurred at <u>1:35</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>James J. Ryan, M.D.</u>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> AM						22b. DATE SIGNED 10 April 1967		
22c. PHYSICIAN'S NAME (Type) <u>James J. Ryan, MD.</u>			22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>4-11-67</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>MARYVILLE TENN.</u>		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR <u>Frogin 389 R.T. Ave NW Wash. DC.</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>APR 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



*10*  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #8 Film #G388 5/2/67 pg

CERTIFICATE OF DEATH

05470

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>	c. LENGTH OF STAY IN 1b <b>19 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>	d. STREET ADDRESS <b>3909 North 5th Street</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emil</b>	First <b>James</b>	Middle <b>Rinaldi</b>	Last Month <b>April</b> 23 19 67 Doy Year
4. DATE OF DEATH <b>Mar. 9, 1967</b>	5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>1912</b>	9. AGE (In years lost birthday) <b>53 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USN</b>	11. BIRTHPLACE (County & State, or foreign country) <b>St Louis Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	13. FATHER'S NAME <b>Michele Rinaldi</b>	14. MOTHER'S MAIDEN NAME <b>Louise Bello</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>
16. SOCIAL SECURITY NO. <b>490 44 9139</b>	17. INFORMANT <b>Arlington Va.</b> Address <b>Mrs. Patricia M. Rinaldi, 3909 North 5th St.</b>	INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG</b> 16 3X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) _____ (c) _____ DUE TO lost. _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>April 4</b> , 19 <b>67</b> , to <b>April 23</b> , 19 <b>67</b> that <b>(I)</b> (we) last saw the deceased alive on <b>April 23</b> , 19 <b>67</b> , and that death occurred at <b>615PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>R.N. Hood</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>Apr. 24, 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>R.N. HOOD MD</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, BRINOVA (Specify) <b>BRINOVA</b>		23b. DATE THEREOF <b>4/26/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery</b>
24. FUNERAL DIRECTOR Murphy Funeral Home ADD <i>Johny Thomas</i> <b>3524 Columbia Pike, Arlington, Va.</b>		25a. REC'D BY REGISTRAR <b>APR 27 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

05473

05471

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Montgomery County, Maryland		b. STATE Maryland Prince Georges Co.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda 1 hr		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1704 Hannon St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS Hyattsville, Md.	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Robert		4. DATE OF DEATH April 9 1967	
5. SEX male 6. COLOR OR RACE white MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH April 9, 1967		9. AGE (In Years last birthday) IF UNDER 1 YEAR Months Days Hours Min. yrs. 1967 0 9 53 min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Rene Robert		14. MOTHER'S MAIDEN NAME Jacqueline Planté Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank and dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT father - wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X DUE TO Prematurity + multiple congenital anomalies			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) DUE TO			
} (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While Not While factory, street, office bldg., etc.) p.m. at work <input type="checkbox"/> at work <input type="checkbox"/>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 9, 1967, to April 9, 1967, that (I) (we) last saw the deceased alive on April 9, 1967, and that death occurred at 10 AM, from the causes and on the date stated above.		22a. SIGNATURE M.D.	
22c. PHYSICIAN'S NAME (Type) <i>J. Howard Reiter</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED	
23a. BURIAL CREMATION REMOVAL (Specify) 23b. DATE THEREOF 4/10/67		23c. NAME OF CEMETERY OR CREMATORIAL Suburban Hospital	
23d. LOCATION (City, town or county) Bethesda Montgomery - Md. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs. Amelia Carter - Administrator - " "		25a. REC'D BY REGISTRAR APR 12 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

AFH 13 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
**05476****MARYLAND STATE DEPARTMENT OF HEALTH****DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND****CERTIFICATE OF DEATH****05472**

Item #2 a,b,c &amp; d Film #G3881125167

## 1. PLACE OF DEATH

## a. COUNTY

*Montgomery*

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

*Silver Spring*

## c. LENGTH OF STAY IN 1b

*6 yrs 5 months*

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

*Althea Woodland Nursing Home, 1000 Daleview Dr.*3. NAME OF DECEASED  
(Type or print)First  
*Carrie*Middle  
*F.*Last  
*Robinson*

## 5. SEX

Female

## 6. COLOR OR RACE

white

WIDOWED NEVER MARRIED DIVORCED 

## 7. MARRIED

NEVER MARRIED DIVORCED WIDOWED MARRIED NEVER MARRIED

STAGE

Year 2 1996 and 1997 1998 and 1999

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05475

## CERTIFICATE OF DEATH

05473

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH <b>Bethesda</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DC</b> b. COUNTY <b>-----</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN b <b>2 hrs. 30 min.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Angela</b>		First <b>A</b> , Middle <b>G.</b> , Last <b>Rota</b>	4. DATE OF DEATH Month <b>April</b> , Day <b>1</b> , Year <b>1967</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr 15 1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>
13. FATHER'S NAME <b>Joseph De Paolis</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Bompiani</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Address</b>	17. INFORMANT <b>Carlo Rota-Son</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Hemopericardium</b> DUE TO <b>4201</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myocardial Rupture</b> DUE TO (c) <b>Acute Myocardial Dolorition</b> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH 1 day. approx. 2 weeks.</span>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>
20f. (City or town) <b>Bethesda</b> (County) <b>Maryland</b> (State) <b>MD</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) ( <b>this hospital</b> ) attended the deceased from <b>March 1967</b> to <b>April 1, 1967</b> , that (I) <b>last</b> saw the deceased alive on <b>April 1, 1967</b> , and that death occurred at <b>Bethesda</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>J. Blaine Fitzgerald</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4/1/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Dr. J. Blaine Fitzgerald</b>		22d. ADDRESS <b>Bethesda</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-4-1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cemetery</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		ADDRESS <b>N.W. 1st St. Wash. D.C.</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>
			25b. REGISTERAR'S SIGNATURE
			DATE <b>APR 10 1967</b>

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**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL, RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #7 Film#G387 4/18/67 pc

05476

CERTIFICATE OF DEATH

05474

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE — — — b. COUNTY — — —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. LENGTH OF STAY IN lb <b>6 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Randolph Hills Nursing Home</b>				d. STREET ADDRESS <b>3420 16th St. N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Jeanne L.</b>	Middle <b>Rowan</b>	Lost	4. DATE OF DEATH Month <b>April</b> - Day <b>9</b> - Year <b>1967</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>11-10-86</b>	9. AGE (In years lost, birthday) <b>80 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Concert Pianist</b>		10b. KIND OF BUSINESS OR INDUSTRY — — —		11. BIRTHPLACE (County & State, or foreign country) <b>New York City, NY</b>	
13. FATHER'S NAME — — —				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) — — —		16. SOCIAL SECURITY NO. — — —		17. INFORMANT <b>Mr. Ceser Aiello - 725-15th St. N.W. Wash. D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3328</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. — — —		DUE TO (b) DUE TO (c)		Cerebral Hemorrhage Arterosclerotic Vascular Disease INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Debilities like J Sain</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956, 19</b> to <b>April 9, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 22, 1967</b> , and that death occurred at <b>905 M</b> , fram causes and on the date stated above.					
22a. SIGNATURE <b>Marvin Fuks</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22b. DATE SIGNED <b>4-9-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Marvin Fuks MD</b>		22d. ADDRESS <b>5311 Connecticut Ave. DC</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>4-11-1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Cedar Hill Crematory</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawkers Sons</b>				23d. LOCATION (City or Town) <b>Suitland, Md.</b>	
				25a. REC'D BY REGISTRAR <b>APR 14 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles George</b>	

11860

HEAD TO 100%

67128

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05477

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05475

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN 1b <b>3 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2358 Glenmont Circle</b>		d. STREET ADDRESS <b>2358 Glenmont Circle</b>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth</b>		First <b>Georgia</b>	Middle <b>Rowles</b>
		Lost <b>Nov 25, 1921</b>	4. DATE OF DEATH Month <b>4</b> Doy <b>30</b> Year <b>1967</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED NEVER MARRIED WIDOWED DIVORCED <b>None</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>Teller</b>		8. DATE OF BIRTH <b>1921</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland Nat'l Bank</b>		9. AGE (In years at birthday) <b>45</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <b>George Smoke</b>		14. MOTHER'S MAIDEN NAME <b>Annes Krall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>192-12-8409</b>	
17. INFIRMAN <b>William Rowles</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive aspiration of vomitus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>921.0</b> (b) <b>with asphyxiation</b> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? <b>YES</b>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>Deceased vomited &amp; aspirated vomitus</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased vomited &amp; aspirated vomitus</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>1:00 4-30 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Silver Spring</b>		(County) <b>Montgomery</b>	
(State) <b>Md</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>4/30/1967</b>	
ACTUAL SIGNATURE <b>Belden Reap</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D., Baltimore</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL(SPECIFY) <b>Trans-Burial</b>		23b. DATE THEREOF <b>May 3, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Homewood Cemetery</b>		23d. LOCATION (City or Town) <b>Pittsburg, Penna.</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas, Jr. Bethesda Warner E. Pumphrey, Inc.</b>		25a. ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>	
25b. REC'D BY REGISTRAR <b>Charles Judge</b>		25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

67860

17120

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #9 Film #G388 578767 pc

05478

## CERTIFICATE OF DEATH

05476

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7/2 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda(rural)</b>		c. LENGTH OF STAY IN 1b <b>76 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>		d. STREET ADDRESS <b>916 North Kemper Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First	Middle <b>Louise</b>	Last <b>Ryan</b>	4. DATE OF DEATH Month <b>April</b>	Day <b>29</b>	Year <b>19 67</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 31, 1919</b>	9. AGE (In years last birthday) <b>47 87 yrs.</b>	IF UNDER 1 YEAR Months <b>4</b>	IF UNDER 24 HRS. Days <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Allston, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Herbert F. Dwyer</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Kiley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>025 18 7819</b>		17. INFORMANT <b>Thomas J. Ryan</b>		916 North Kemper Street Address <b>Alexandria, Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>174X</b>		INTERVAL BETWEEN ONSET AND DEATH					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>NA</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 12</b> , 19 <b>67</b> , to <b>Apr. 29</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>Apr. 29</b> , 19 <b>67</b> , and that death occurred at <b>1:45 AM</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>April 29, 1967</b>					
22a. SIGNATURE <b>R.L.GIBBS MD</b>		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <b>R.L.GIBBS MD</b>		22d. ADDRESS <b>Naval Hospital Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/3/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Arlington National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>		
24. FUNERAL DIRECTOR <b>Everley-Wheatley Funeral Home</b>		ADDRESS <b>1500 W Braddock Rd.</b>	25a. REC'D BY REGISTRAR <b>DATE</b>	25b. REGISTRAR'S SIGNATURE <b>Judge</b>			

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